Health Care Financing Administration Rulings

On Medicare, Medicaid,
Professional Standards Review
and Related Matters

Publication No. MBR-3 (4-79)
April 1979

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Foreword

Programs of the Health Care Financing Administration—including Medicare, Medicaid, and Professional Standards Review Organizations—affect millions of people throughout the United States. To fully understand these programs, it is necessary to have access to the administrative instructions and manuals which guide staffs of Federal and State agencies and HCFA contractors in implementing the programs. In addition, official public rulings of the agency show how regulations are interpreted and applied.

Thus, in publishing *HCFA Rulings* quarterly, HCFA's intent is to observe the spirit of the Freedom of Information Act: to keep the public informed about the agency's handling of the public's business. As required by law, this document contains listings and indexes of current program regulations, manuals, instructions, rulings, and decisions. In addition, it includes illustrative case decisions which serve as binding precedents upon those who administer the HCFA programs and upon those who serve as hearing officials in various program appeals. These decisions are being compiled in a timely fashion in order to promote consistency in interpretation of policy and adjudication of disputes.

HCFA Rulings should be of use to Medicare and Medicaid beneficiaries, Federal and State employees who administer these programs, intermediaries, carriers, providers of services under the programs, other contractors to HCFA, attorneys, court and hearing personnel, and interested members of the public.

HCFA Rulings is a successor to *SSA Rulings*, in which Medicare cases and indexes appeared prior to the HEW reorganization of 1977. At that time, the Medicare program was transferred to this agency from the Social Security Administration.

The first two issues of *HCFA Rulings* have contained predominantly Medicare case materials. However, this issue and subsequent issues carry cases also concerning Medicaid and Professional Standards Review Organizations. In addition, this issue contains the last of the rulings pertaining to the Medicare program which were previously published as Social Security Rulings when the Medicare program was a part of the Social Security Administration.

Leonard D. Schaeffer
Administrator
Health Care Financing Administration

Subscription Information

Copies of the *Health Care Financing Administration Rulings* can be obtained by subscription from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 at a cost of $2.00 per copy for each quarterly publication ($2.50 for foreign mailings) and $2.50 for each cumulative edition ($3.20 foreign). The full subscription price is $9.75 per year ($12.25 for foreign subscription).

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SECTION 1861(a) and (j)—HOSPITAL INSURANCE BENEFITS—DURATION OF SPELL OF ILLNESS—INPATIENT IN SKILLED NURSING FACILITY

HCFAR 79–28

An individual entitled to hospital insurance benefits was discharged on October 7, 1976, from a skilled nursing facility where she had been receiving posthospital services, after having used up 100 days of such services in her current spell of illness, and was readmitted to a hospital on December 4, 1976. Upon discharge, she returned to the skilled nursing facility on December 18, 1976. *Held,* since less than 60 days had elapsed between her discharge from the skilled nursing facility and the date of her readmission to the hospital, a new spell of illness did not start on the latter date; her subsequent readmission to the skilled nursing facility on December 18, 1976, occurred within the same spell of illness; and she had already exhausted the number of days for which payment could be made on her behalf for posthospital extended care services during that spell of illness.

Under the provisions of sections 1812(a) and 1861(i) of the Social Security Act, an individual entitled to hospital insurance benefits under Part A is eligible to have payment made on his behalf to a participating skilled nursing facility for up to 100 days of extended care services furnished to him in a spell of illness, if he was transferred to such facility generally within 14 days after discharge from a hospital in which he was an inpatient for not less than 3 consecutive days.

The term "spell of illness" is defined in section 1861(a) of the Social Security Act as meaning a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, * * * and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatint of a hospital nor an inpatient of a skilled nursing facility.

The facts are as follows: L, a hospital insurance beneficiary, was admitted to the A Community Hospital on May 14, 1976, suffering from congestive heart failure. On May 23, 1976, she was discharged from the hospital and admitted to the B Sanitorium, where she remained until discharged for immediate admission to the C Convalescent Hospital on June 30, 1976. She remained at the C Convalescent Hospital as an inpatient until her discharge on October 7, 1976. On December 4, 1976, after sustaining a fractured hip, L was readmitted to the A Community Hospital and remained there until discharged to the C Convalescent Hospital on December 18, 1976, where she was an inpatient until February 4, 1977.

Benefits were paid on L's behalf to the B Sanitorium and the C Convalescent Hospital for the posthospital services she received while an inpatient in those skilled nursing facilities during the first 100 days immediately following her initial discharge from the A Hospital. However, her

eligibility for extended care services during this initial spell of illness was exhausted on August 30, 1976.

Since less than 60 days elapsed between L's discharge from the C Convalescent Hospital on October 7, 1976, and her second admission to A Hospital on December 4, 1976, it was determined that the later admission did not initiate a new spell of illness, and that no payment could be made on L's behalf for the services she received at the skilled nursing facility beginning December 18, 1976. This determination was protested on the basis that L did not require skilled nursing or other skilled rehabilitation services on a daily basis, which as a practical matter could only be provided in a skilled nursing facility on an inpatient basis after September 16, 1976, and, therefore, lost her inpatient status on September 16, 1976, when the only services rendered her were less than skilled nursing care, and not on October 7, when she was actually discharged.

The issue to be resolved here is whether a new spell of illness, as defined in section 1861(a) of the Act, began on December 4, 1976 with L's readmission to the A Community Hospital, so as to permit program payment on her behalf to be made to the C Convalescent Hospital for inpatient services furnished L commencing December 18, 1976.

The beginning of a spell of illness, as defined in section 1861(a) supra. relates to the nature of the services rendered to an individual (i.e., inpatient hospital or extended care); the end of a spell of illness is related to the type of the institution itself. Once a spell of illness has started, it continues as long as the individual remains an inpatient in a hospital which meets at least the requirements of section 1861(e)(1), or skilled nursing facility which meets at least the requirements of section 1861(j)(1) of the Act, even though he may no longer require or receive skilled care.* Thus, a spell of illness may continue even though the institution providing services to the individual is one that does not meet all of the requirements for participation or payment as a provider of services.

A inpatient of a skilled nursing facility is a person who has been formally admitted to such facility for bed occupancy for the purpose of receiving inpatient services. There is no basis under section 1861(a) of the Act, which defines a "spell of illness," for terminating an individual's status as an inpatient while physically in a skilled nursing facility merely because the services which she is receiving are no longer covered.

It is recognized that there may be situations where these criteria for defining a "spell of illness" would appear harsh and disadvantageous to persons who remain in skilled nursing facilities after having exhausted their benefit days, even though they may no longer be receiving skilled nursing care or skilled rehabilitation services. However, the legislative history of hospital insurance indicates that Congress was aware of these limitations, and could have remedied them by substituting a subjective test for determining the end of a "spell of illness" (i.e., the type of care fur-

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* Section 1861(j) of the Act provides that "the term 'skilled nursing facility' means . . . an institution . . . which . . . (1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care or (B) rehabilitation services for the rehabilitation of injured, disabled or sick persons. . . ."

nished), for the objective one now in the law, (i.e., the nature of the institution). Nevertheless, the requirements were set up in this manner specifically as a means of controlling the overall costs of the Medicare program, which was in turn intended to provide a basic protection against the costs of medical care for relatively short term acute illnesses. In 1967, a change in the criterion for determining the end of a "spell of illness" was suggested to the congressional committees considering amendments to the Social Security Act. However, by permitting the objective test to remain in the law, it was the clear intent of Congress that an individual who has exhausted the maximum number of days of inpatient care in a hospital or skilled nursing facility in a spell of illness should be able to qualify for such benefits again only if he does not receive institutional care for 60 consecutive days.

L's initial spell of illness, which began with her admission to the A Community Hospital on May 14, 1976, can be said to have continued beyond her discharge from the C Convalescent Hospital, a participating skilled nursing facility, on October 7, 1976, and until a period of 60 consecutive days had elapsed during which she was not an inpatient of a hospital or a skilled nursing facility. Since this did not occur before December 4, 1976, when L reentered the A Community Hospital, a new spell of illness did not start on that date and, therefore, the subsequent readmission to the C Convalescent Hospital occurred within the initial spell of illness for which L had already exhausted her entitlement to have payment made on her behalf for extended care services.

Accordingly, it is *held*, that L is not entitled to have payment of hospital insurance benefits made on her behalf for the services she received at the C Convalescent Hospital commencing on December 18, 1976.

(X—Refer to SSR 69–62)

SECTION 1861(a) and (i)—HOSPITAL INSURANCE BENEFITS—DURATION OF SPELL OF ILLNESS—MORE THAN ONE TYPE OF ILLNESS INVOLVED—CONTINUITY OF STAY AS INPATIENT IN SKILLED NURSING FACILITIES

42 CFR 405.120 HCFAR 79–29

An individual entitled to hospital insurance benefits was admitted in January 1976 to a skilled nursing facility after a qualifying hospital stay for treatment of diverticulitis. She remained there continuously, using up the 100 days of post-hospital extended care services to which she was entitled in that spell of illness. On February 20, 1977, she was discharged to another skilled nursing facility. While there, she fell and broke her hip, was readmitted to the hospital on May 17, 1977, for 3 weeks, and returned to the latter skilled nursing facility. *Held*, a new spell of illness did not start on May 17, 1977, when she was readmitted to the hospital for treatment of a broken hip since there had not elapsed a period of 60 consecutive days during which she was not an inpatient either of a hospital or a skilled nursing facility at any time since her initial hospital stay; thus, her second admission, and later readmission to the skilled nursing facility on June 4, 1977, occurred within the initial spell of illness. *Held further*, since she had already exhausted the number of days of extended care in that spell of illness for which payment could be made on her behalf, no payment can be made to the skilled nursing facility for the services it furnished the claimant beginning June 4, 1977.

An individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act is eligible to have payment made on his behalf to a participating skilled nursing facility for up to 100 days of extended care services furnished to him in a spell of illness, if he was transferred to such facility generally within 14 days after discharge from a hospital in which he was an inpatient for not less than 3 consecutive days. As provided in section 1814(a) (2) (C) of the Act, the extended care services must be needed:

> . . . for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hosptal services; . . .

The term "spell of illness" is defined in section 1861(a) of the Social Security Act as meaning a period of consecutive days—

> (1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, * * * and
>
> (2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is either an inpatient of a hospital nor an inpatient of a skilled nursing facility.

F, an individual entitled to hospital insurance benefits, was hospitalized for the treatment of diverticulitis and, after a qualifying hospital stay, was admitted to the A Nursing Home on February 1, 1976. She remained there as an inpatient until transferred to the D Convalescent Home on February 20, 1977. While there, she fell, broke her hip and was immediately hospitalized on May 17, 1977. On her discharge from the hospital, June 4, 1977, she was readmitted to the D Convalescent Home. Payment was made on F's behalf to the A Nursing Home for the posthospital extended care services she received there for the 100 days, February 1, 1976, through May 11, 1976. A claim has also been filed for payment to the D Convalescent Home on F's behalf for the extended care services she was furnished there beginning June 4, 1977, after her second hospital discharge on that date.

Since F's eligibility for extended care services was exhausted on May 11, 1976, she could become entitled to have payment made on her behalf for the services she was furnished by the D Convalescent Home beginning June 4, 1977, only if her second admission to the hospital on May 17, 1977, initiated a new "spell of illness" as defined above. In this connection, it is not material that the two periods of hospitalization were for different reasons, since the Social Security Act does not define a spell of illness in terms of type of illness.

A spell of illness begins when a beneficiary is furnished inpatient hospital services in a qualified hospital or extended care services in a qualified skilled nursing facility. A "qualified" hospital is one which meets all the requirements to participate in the program as a provider of services and a "qualified" skilled nursing facility is one which meets all the requirements

to participate in the program, whether or not they actually participate. Once a spell of illness has started, it continues as long as the individual remains an inpatient in any hospital which meets at least the requirements of section 1861(e) (1) of the Act or in a skilled nursing facility which meets at least the requirements of section 1861(j)(1), even though he may no longer require or be receiving skilled nursing or skilled rehabilitation care.

F was continuously an inpatient of a participating skilled nursing facility after May 11, 1976, remaining in the A Nursing Home until her transfer to the D Convalescent Home on February 20, 1977. Therefore, the spell of illness which began when she was hospitalized initially for treatment of diverticulitis in February 1976 had not ended prior to her admission to a hospital for treatment of a broken hip, on May 17, 1977, since she had not been out of a hospital or a skilled nursing facility for 60 consecutive days. A new spell of illness could not therefore have started on May 17, 1977, and her admission to the hospital on that date must be considered to have occurred within the initial spell of illness.

It is accordingly *held* that, since F had already exhausted her entitlement to have payment made on her behalf for extended care services during that spell of illness as of May 11, 1976, payment may not be made to the D Convalescent Home for services furnished F commencing June 4, 1977.

(X—Refer to SSR 70–17)

SECTIONS 1812(a) and 1862(a)(9)—HOSPITAL INSURANCE BENEFITS—NONCOVERED CARE IN HOSPITAL

42 CFR 405.162 HCFAR 79–30

An individual, entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was an inpatient of a participating hospital from January 16, 1977 to March 19, 1977 receiving treatment for a fractured wrist and congestive heart failure. The medical evidence, including the individual's progress notes and the physician's order sheet, established that her condition had stabilized after February 9 and that she could be transferred to a skilled nursing facility. *Held*, coverage for the care and services furnished by the hospital is denied after February 9, 1977 because the services received thereafter did not constitute covered inpatient hospital services as contemplated by section 1812(a) of the Social Security Act but were custodial in nature and therefore excluded by section 1862(a)(9) of the Act.

M, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act was an inpatient at the N Hospital from January 16, 1977, to March 19, 1977. Her admitting diagnosis was a fractured right wrist, however, on January 28, 1977, while hospitalized, she suffered congestive heart failure. Payment has been made on M's behalf for inpatient hospital services for the period commencing January 16, 1977 through February 9, 1977. However, coverage for the period beginning February 10, 1977, and extending through March 19, 1977, was denied on the basis that the services were custodial in nature and therefore specifically excluded

from coverage by section 1862(a)(9) of the Social Security Act. M has protested this decision.

The Social Security Act provides, as pertinent here, that the benefits provided to an individual by the hospital insurance program under Part A shall consist of entitlement to have payment made on his (her) behalf for inpatient hospital services for up to 150 days during any spell of illness (benefit period). However, section 1862(a) of the Act states, as pertinent here, that:

> Notwithstanding any other provisions of this title, no payment may be made under part A or part B of any expenses incurred for items or services—
>
> * * * * *
>
> (9) where such expenses are for custodial care * * *

The issue to be decided in the instant case is whether the services M received from February 10, 1977, to March 19, 1977, were covered inpatient hospital services as contemplated by section 1812(a) of the Act or whether they were custodial in nature and therefore excluded from coverage in accordance with section 1862(a)(9) of the Act.

The medical evidence shows that M was admitted to the hospital for a fractured wrist and was treated with a closed reduction, i.e., a nonoperative method of reducing the fracture and application of a plaster cast. On January 29, 1977, medication was ordered and given to M for possible congestive heart failure. According to the progress notes on M's chart her condition steadily improved after that date. Generally, her condition was described as "doing well." On the physician's order sheet there was an entry dated February 7, 1977, which indicated that M should be transferred to the skilled nursing facility unit, a distinct part of the hospital. Further, on February 10, 1977, an entry on the progress notes stated that M refused to be transferred to the skilled nursing facility. The records indicate that by that date her condition had stabilized and she was experiencing no difficulty with either her fractured wrist or her heart condition. On February 28, there was an entry on the progress notes which showed that M could have been discharged at any time but there was a problem finding home care for her.

All pertinent notations on the medical record indicate that M no longer required hospital care but could have received proper treatment in a less intensive facility. However, it appears that she did not wish to be transferred to this type of facility but wished to remain as an inpatient in the hospital.

It is determined from the evidence, that the services provided M beginning February 10, 1977, were not required to be given in a hospital on an inpatient basis. The records show that M's condition had stabilized by that time and that she was experiencing no difficulty either with the fracture or her heart condition. The progress notes and physician's orders show that as of February 10, 1977, the services needed by M could have been given outside of a hospital setting.

Accordingly, it is *held,* coverage is denied for care and services furnished to M by the N Hospital from February 10, 1977—March 19, 1977 as they

were not covered inpatient hospital services as contemplated by section 1812(a) of the Social Security Act but were custodial in nature and therefore excluded by section 1862(a)(9) of the Act.

(X—Refer to SSR 71–7)

SECTION 1812—HOSPITAL INSURANCE BENEFITS—PSYCHIATRIC HOSPITAL CONFINEMENT ON EFFECTIVE DATE OF ENTITLEMENT—190-DAY LIFETIME LIMITATION FOR PSYCHIATRIC HOSPITAL CARE

HCFAR 79–31

Where an individual became entitled to hospital insurance benefits beginning October 1, 1969, while an inpatient of a psychiatric hospital where she had been continuously confined since 1944, *held*, payment is precluded for the services furnished by the hospital beginning October 1, since she had been an inpatient of the hospital for the entire 150-day period immediately before such entitlement, thus exhausting the total number of benefit days available in her first spell of illness (benefit period). *Further held*, such preentitlement days may not be counted against her lifetime limitation of 190 days for inpatient psychiatric hospital care.

The benefits provided an individual by the hospital insurance program include entitlement to have payment made on his behalf for hospital and medical services, including inpatient psychiatric hospital services, for up to 90 days during any spell of illness plus any or all of his 60 "lifetime reserve" days which he has not used in any previous spell of illness (benefit period). For care of the individual in participating psychiatric hospitals, there is a lifetime limit of 190 hospital benefit days.

P became entitled to hospital insurance benefits beginning October 1, 1969. On that day she was an inpatient of the U State Psychiatric Hospital where she had been continuously confined since 1944. A claim for payment on P's behalf for the inpatient hospital services furnished her by the U Hospital beginning October 1, 1969, was denied pursuant to section 1812(c) of the Act on the ground that, as of that date, P had already been hospitalized in the U Psychiatric Hospital in excess of the number of days for which payment could be made. P's husband has protested this determination, stating that, since she did not become entitled to hospital insurance benefits until October 1, 1969, the period of hospitalization prior thereto should not be counted and payment should be made for the inpatient hospital service she received beginning with that date.

Two issues must be resolved in this case: (1) whether on October 1, 1969, P must be deemed to have already exceeded the 150 days of inpatient psychiatric hospital services for which payment could be made in her initial spell of illness; and (2) whether, as of that date she had also used any portion of her 190-day lifetime limit for inpatient psychiatric hospital services.

Section 1812(c) of the Act provides that if the individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is so entitled, the number of days in the 150-day period immediately before

that day which he has already spent as an inpatient of a psychiatric hospital will be included in determining the number of days for which payment may be made in his initial spell of illness for inpatient psychiatric hospital services or for services in a general hospital where the care the individual receives is primarily for the diagnosis or treatment of a psychiatric illness. Since she had been an inpatient of the psychiatric hospital on each day of the 150-day period immediately before her first day of entitlement, there were no inpatient psychiatric hospital benefit days left for which payment could be made during that spell of illness. However, in her first spell of illness she could receive up to 150 days of inpatient hospital service in a TB hospital or a general hospital (provided the care in the general hospital was not primarily of a psychiatric nature).

In order for P to be eligible for payment for psychiatric hospital services, it would be necessary for her to be discharged from the hospital and no longer be an inpatient of a hospital or institution that furnishes primarily skilled nursing care or skilled rehabilitation services for 60 days or more; and begin a new "spell of illness" (benefit period), in accordance with section 1861(a) of the Act, which defines a spell of illness as follows:

> a period of consecutive days . . . beginning with the first day (not included in a previous spell of illness) . . . on which such individual is furnished inpatient hospital services or extended care services . . . and . . . which occurs in a month for which he is entitled to benefits under part A and ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.

There remains the question whether P's preentitlement days in the U Psychiatric Hospital should also be counted against the lifetime limitation of 190 days for psychiatric care provided by section 1812(b)(3). Although section 1812(c) requires that preentitlement days be counted against the 150 days' eligibility for hospital benefits in P's initial spell of illness, if the care she receives is as an inpatient of a psychiatric hospital or a general hospital which furnishes her care primarily of a psychiatric nature, it specifically excludes such days in determining her lifetime limitation of 190 days for psychiatric care.

Accordingly, it is *held*, payment may not be made on P's behalf for the inpatient psychiatric hospital services furnished her by the U State Psychiatric Hospital during her initial "spell of illness" beginning October 1, 1969. It is *further held*, however, that the preentitlement days of inpatient services in the U Hospital will not be counted against P's lifetime limitation of 190 days for psychiatric care.

(X—Refer to SSR 71-36)

SECTION 1814(a) and 1862(a) (42 U.S.C. 1395f(a) and 1395y(a))—HOSPITAL INSURANCE BENEFITS—CUSTODIAL CARE—AVAILABILITY OF BED IN SKILLED NURSING FACILITY
42 CFR 405.126, 405.127, 405.128, 405.310 and 405.1627(a)(2)

HCFAR 79–32

Where claimant for hospital insurance benefits was hospitalized November 26, her condition stabilized by December 16, and constant availability of physicians and complex medical equipment generally found only in a hospital were no longer required but physician recertified her continued need for hospitalization pending availability of bed in skilled nursing facility, *held*, care received after December 16, a supportive level of care, does not come within purview of section 405.1627 of the Health Care Financing Administration Regulations which is applicable only if evidence demonstrates need of a covered level of post-hospital extended care services and not merely custodial care.

P, a hospital insurance beneficiary, was admitted to X Hospital by stretcher on November 26, 1976, after a fall in which her left shoulder was fractured. Four years previously she had fractured a hip and had experienced a gradual deterioration of physical powers with a loss of ability to ambulate and loss of coordination in her limbs. Other ailments included double vision, a marked stress tremor, and a poor appetite. It was noted that she fell easily, could barely feed herself, and had no urinary control.

Section 1814 of the Social Security Act, in pertinent part, provides:

(a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1866 and only if—*

* * * * * *

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose. . . .

Section 1862 of the Act provides, in pertinent part:

(a) Nothwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;—

* * * * * *

(9) where such expenses are for custodial care . . .

Physician's orders called for a house diet as tolerated, routine lab tests, chest X-ray, Demerol for pain as needed, and medication for Parkinson's

* References to "(g)" and to "Section 1876" were added by the 1972 Amendments (P.L. 92-603).

disease. An indwelling catheter was used to control P's incontinence. During the first week P was very lethargic, sleeping at long intervals. During the period of December 4, 1976, through December 7, 1976, she was awake for longer periods and was more talkative. From December 8–11, she was walking some with help but was very confused. From December 12–15, although still confused, P had made improvement in both eating and ambulation. By December 16, she was speaking clearly, seemed much more alert and oriented, and was up in a chair.

Hospital insurance benefits were paid on P's behalf for the period November 26 through December 16, 1976. Further, coverage was denied on the basis that the type of care she received thereafter was primarily in the area of supportive noncovered care, such as assistance in bathing, dressing, and personal hygiene. P appealed this determination, seeking coverage for the remainder of her hospitalization from December 17, 1976, through January 20, 1977.

The specific issue herein is whether it was medically necessary for P to receive inpatient hospital and related services during all or part of the period in question, given the fact that no skilled nursing facility beds were available, on the grounds that P was in need of at least skilled nursing facility care.

The evidence shows that P required skilled medical attention in a hospital after admission since close observation of her multifarious conditions was necessary and the dosage of several medications had to be closely monitored. Therefore, it was not unreasonable for payment to have been made for the period November 26 through December 16, 1976.

However, on December 16, 1976, P was up in a chair and was able to be up regularly until her discharge. Her appetite, which previously had been poor, was noticeably better. She spoke more clearly and frequently and seemed more conscious of her surroundings. It was at this point when her condition seemed to have stabilized and she was no longer in any immediate danger. She no longer required the constant availability of physicians and complex medical equipment generally found only in a hospital.

The evidence further indicates that on December 13, 1976, and on January 12, 1977, the attending physician recertified as to the need for the claimant's continued hospitalization because she was awaiting a bed in a skilled nursing facility.

Section 405.1627(a) of the Health Care Financing Administration Regulations provides in pertinent part:

> (2) A physician may certify or recertify to the need for continued hospitalization if he finds that the patient could receive proper treatment in a skilled nursing facility, but no bed is available in a participating skilled nursing facility. Where this is the basis for the physcian's certification or recertification, the required statement should so indicate; also, the physician should attempt on a continuing basis to place his patient in a participating skilled nursing facility as soon as a bed becomes available.

Payment for continued hospitalization may be made when the attending physician certifies in accordance with the above and the evidence shows that the patient no longer requires a hospital level of care, but does require a *covered level* of post-hospital extended care services and no bed is available in a participating skilled nursing facility.

Section 405.126 of the Regulations defines "post-hospital extended care" as follows:

> For a beneficiary to meet the skilled nursing facility level of care, he must need, on a daily basis, . . . skilled nursing services or skilled rehabilitation services . . . which as a practical matter . . . can be provided only in a skilled nursing facility on an inpatient basis, and which are for either (1) a condition for which he received inpatient hospital services . . . or (2) for a condition which arose while he was in a skilled nursing facility receiving care for a condition for which he received inpatient hospital services.

Section 405.127 of the Regulation defines skilled services as services which:

> "(1) Require the skills of technical or professional personnel . . . and (2) are provided either directly by or under the supervision . . . of such personnel."
>
> * * * * *
>
> (d) *Personal care services.* Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services. . . . Personal care services include, but are not limited to, the following:
> (1) Administration of routine oral medications, eye drops, and ointments;
> (3) Routine services to maintain satisfactory function of indwelling bladder catheters:
>
> * * * * *
>
> (11) Assistance in dressing, eating, and going to the toilet.

Section 405.310 of the Regulations, as amended, provides in part . . .

> —Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services.
>
> * * * * *
>
> (g) Custodial care (in the case of extended care services, any care which does not meet the definition of extended care in §§405.126–405.128);

During the period December 17, 1976, to January 20, 1977, P received routine catheter care, attention to her diet, aid in eating, and aid in personal hygiene. She also required assistance in taking oral medications for a variety of conditions which were either stable on admission or had since stabilized. The mental confusion which persisted did not appear to cause any complicating problems.

Thus, the evidence shows that the claimant required and received services which were primarily custodial in nature during the contested period. Custodial care does not come within the purview of 42 CFR 405.1627(a)(2) which is applicable only if the claimant requires a covered level of post-hospital extended care services and no bed is available in a participating skilled nursing facility. Accordingly, it is *held* that coverage is denied for the services provided to P in the hospital for the period December 17, 1976 to January 20, 1977.

(X—Refer to SSR 73–50)

307–578 O - 80 - 2

SECTION 1861(i)—HOSPITAL INSURANCE BENEFITS—3-CONSECUTIVE-DAY HOSPITAL STAY REQUIREMENT PRIOR TO ADMISSION TO SKILLED NURSING FACILITY

42 CFR 405.120(c) HCFAR 79–33

> A hospital insurance beneficiary under title XVIII of the Social Security Act was admitted as an inpatient to a participating hospital on June 6, 1977. She was discharged on June 8, 1977, and transferred to a skilled nursing facility on that date. *Held*, payment for care and services furnished by the skilled nursing facility may not be made on her behalf since she had not been an inpatient at the hospital for at least 3 consecutive days prior to admission to a skilled nursing facility, as required under section 1861(i) of the Act. For purposes of this requirement, section 405.120(c) of the Regulations of the Health Care Financing Administration (42 CFR 405.120(c)) specifically excludes the day of discharge in computing the number of days a person is an inpatient in a hospital.

L, who was entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act was admitted as an inpatient to the P Hospital on June 6, 1977, and discharged on June 8, 1977. On the same day, June 8, 1977, she was transferred to the O Convalescent Hospital, a participating skilled nursing facility. Program payment to the O Convalescent Hospital on L's behalf for the services she received there was denied because L had not met the 3-consecutive-day hospital stay requirement in section 1861(i) prior to her admission to the skilled nursing facility. L protested this decision on the basis that she had been an inpatient on 3 consecutive days, i.e., June 6, 1977, June 7, 1977, and June 8, 1977.

Section 1861(i) of the Social Security Act, as amended, provides in pertinent part that the term "post-hospital extended care services" means extended care services furnished an individual who has met the requirements of section 1814(a)(2)(C) after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. The issue in the instant case is whether payment may be made on L's behalf for the cost of her care at the O Convalescent Hospital. The answer depends upon whether L had been an inpatient of a hospital for at least 3 consecutive days prior to her transfer to the O Convalescent Hospital on June 8, 1977.

In defining the 3-consecutive day requirement in section 1861(i) of the Act, supra, section 405.120 of the Health Care Financing Administration Regulations (42 CFR 405.120) provides in pertinent part that:

> (c) The 3-consecutive-day hospital inpatient requirement is a period of 3 calendar days, beginning with the calendar day of admission even if less than a 24-hour day, and ending with the day before the calendar day of discharge. Thus, in determining whether the 3-consecutive-day requirement is met, the day of admission is counted as one day; the day of discharge is not counted as a day; and each intervening day is counted as a single day.

The undisputed facts in the instant case show that L was admitted to the P Hospital as an inpatient on June 6, 1977, and discharged June 8, 1977. On the same day as her discharge from the hospital she was admitted to

the O Convalescent Home. Under Regulations section 405.120(c) of the Health Care Financing Administration, the day of admission and each succeeding day thereafter up to, but not including, the day of discharge is counted in determining the days elapsed for hospital insurance purposes. Therefore, June 6, 1977, was 1 day; June 7, 1977, the 2d day; June 8, 1977, the day of discharge, is not counted.

Accordingly, L did not meet the 3-consecutive-day hospital stay requirement of section 1861(i) of the Act. It is therefore *held,* payment on behalf of L for care and services furnished to her at the O Convalescent Hospital may not be made.

(X—Refer to SSR 69–63)

SECTIONS 1802 and 1861(j)—HOSPITAL INSURANCE BENEFITS—SKILLED NURSING FACILITY—PORTION OF FACILITY CERTIFIED

42 CFR 405.1102ff. HCFAR 79–34

A hospital insurance beneficiary, after being hospitalized, occupied a semiprivate room of a convalescent home where she had been permanently residing prior to her admission to the hospital. A portion of the convalescent home was certified by the Department of Health, Education, and Welfare as a qualified provider of services participating as a "skilled nursing facility" pursuant to section 1861(j) of the Social Security Act. However, the beneficiary's room was located in a portion of the institution not so certified. *Held,* payment may not be made on the beneficiary's behalf for the services furnished by the institution since she was an inpatient of an uncertified portion of such facility.

L, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act, has resided in the C Convalescent Home as a permanent resident since October, 1974, except for two brief periods when, because of acute illnesses, she required hospital treatment. The first such hospitalization on March 8, 1976, was necessitated by a stroke. Following hospital treatment she was returned to the C Convalescent Home on April 1, 1976. Again on August 4, 1977, L was admitted to the hospital and upon her discharge was immediately return to the Home. L had taken semiprivate accommodations in the Home when she was first admitted in 1974, and has occupied the same room ever since. While hospitalized, she continued to pay the rental charge on her room at the C Convalescent Home so it would be available to her when she returned. Only part of the Home has been certified by the Department of Health, Education, and Welfare for participation as a provider of services under title XVIII of the Social Security Act. However, L's room is located in the part of the Home which has not been so certified and, although advised of this fact, L has insisted on remaining in the room which she prefers. Therefore, based on the fact that the room L occupied was not located in the portion the C Convalescent Home certified for participation under title XVIII, payment has been denied for the services furnished her beginning April 1, 1976, following her hospitalization.

L has protested this determination stating that she feels reimbursement should be made to the extent of the costs which would be reimbursable had she occupied a room in the certified portion of the Home, and that she would thus be liable only for the difference between that sum and the actual cost of her room.

Section 1802 of the Social Security Act provides that:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person *qualified to participate under this title* if such institution, agency, or person undertakes to provide him such services. (Emphasis supplied.)

As pertinent here, the term "provider of services" means a "skilled nursing facility" which is defined in section 1861(j) of the Act as an institution (or a distinct part of an institution) which:

> (1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
>
> (2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
>
> (3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;
>
> (4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;
>
> (5) maintains clinical records on all patients;
>
> (6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;
>
> (7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
>
> (8) has in effect a utilization review plan which meets the requirements of subsection (k);
>
> (9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; . . .
>
> (15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863). . . .

The last of the requirements of section 1861(j) authorizes the Secretary of Health, Education, and Welfare to establish by regulation such further conditions as may be necessary in the interest of health and safety. Those additional conditions are found in sections 405.1101 through 405.1137 of Regulations of the Health Care Financing Administration (42 CFR 405.1101–405.1137).

When a skilled nursing facility meets the requirements of section 1861(j) of the Act and, in addition, meets the other conditions imposed by the

Secretary by regulation, such facility may be certified by the Department of Health, Education, and Welfare as a provider of services eligible to participate under title XVIII of the Social Security Act.

Section 1802, supra, specifically provides that an individual entitled to insurance benefits may obtain medical services from any institution "qualified to participate under this title." It is, therefore, a requirement of the statute that for an institution to participate under title XVIII, such institution must "qualify" and that is accomplished by obtaining certification. No payment can be made to an institution which is not so certified.

Generally, a skilled nursing facility is either certified for participation under title XVIII or is not so certified and thus, unable to participate. However, as in the instant case, situations have developed where a particular institution may qualify for participation in part while another portion of the same facility may not qualify with respect to its physical facilities. Section 1861(j) of the Act specifically provides that a distinct part of an institution may qualify as a skilled nursing facility and thus the distinct portion of the premises which has been found to meet the standards required for certification may be certified and the remaining portion of such institution not certified. Thus, the payment of extended care benefits under part A of title XVIII can be made only on behalf of individuals receiving services and utilizing facilities of the certified portion of the particular institution.

The evidence in the instant case shows clearly that L occupied, by her own choice, a room located in a portion of the C Convalescent Home which was not certified to participate under title XVIII. Accordingly, it is *held*, payment may not be made on L's behalf for the charges she incurred beginning April 1, 1976, since she was an inpatient of an uncertified portion of the C Convalescent Home and payment may be made only to "qualified" institutions pursuant to section 1802 of the Social Security Act.

(X—Refer to SSR 71–16)

SECTIONS 1814(a)(2)(C) and 1862(a)(9)—HOSPITAL INSURANCE BENEFITS—SKILLED NURSING FACILITY—NEED FOR SKILLED SERVICES INITIALLY REQUIRED 30 DAYS AFTER ADMISSION

42 CFR 405.1101(d) HCFAR 79–35

An 88-year-old hospital insurance beneficiary entered a skilled nursing facility on October 18, 1977, after a qualifying hospital stay, with a diagnosis of cerebral arteriosclerosis and benign prostatic hypertrophy. He could feed himself and care for his own personal needs until November 18, 1977, when he contracted pneumonia, and developed a genito-urinary infection and anemia. These conditions required intramuscular injections and insertion of a urethral catheter. *Held*, coverage for the care and services furnished by the skilled nursing facility is precluded for the period from the date of admission to November 18, 1977, by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act since skilled services were not required and the primary purpose of the service furnished was to assist him in meeting the activities of daily living. *Further held*, coverage for the skilled nursing services furnished by the skilled nursing facility beginning November 18, 1977, is also precluded since such services were not for the treatment of any of the conditions for which he was receiving inpatient hospital services prior to transfer to the skilled nursing facility, as required by section 1814(a)(2)(c) of the Social Security Act.

H, an 88-year-old individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was admitted to the G Nursing Home on October 18, 1977, immediately after a prolonged period of hospitalization. The admitting diagnosis at the skilled nursing facility was cerebral arteriosclerosis and benign prostatic hypertrophy. There was no indication of any closely supervised nursing care, physical therapy, medications, or other services which required skilled care until November 18, 1977, when H's condition changed. Payment for the care and services provided H by the G Nursing Home was denied for the entire period on the basis that skilled services were not received or required within 14 days after admission for any of the conditions with respect to which he was receiving inpatient hospital services. H's son has protested this decision.

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including posthospital extended care services for up to 100 days during any spell of illness. Section 1814(a)(2) of the Act provides, as pertinent here, that payment will be made for such services to providers thereof, but only if, among other exceptions not here pertinent, a physician certifies that the services:

(C) . . . are or were required to be given because the individual needs or needed skilled nursing care . . . or skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

Section 1861(h) of the Act provides, as pertinent here, that the term "extended care services" includes nursing care provided to an inpatient of a "skilled nursing facility" by or under the supervision of a registered professional nurse.

Section 1861(i) of the Act defines the term "post-hospital extended care services" as:

> extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 14 days after discharge from such hospital, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital; an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

Section 1861(j) of the Act provides, as pertinent here, that the term "skilled nursing facility" means an institution which—

> (1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Section 1862(a) of the Act provides that:

> Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
>
> * * * * *
>
> (9) where such expenses are for custodial care.

"Custodial care" is that type of care which is designed essentially to assist an individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, use of the toilet, assistance in bathing, dressing, and feeding, preparation of special diets, and supervision of medication which can usually be self-administered, and which do not entail or require performance by or supervision by trained medical or paramedical personnel.

The general issue to be resolved in the instant case is whether coverage is available for the period commencing October 18, 1977. The specific issue is whether H required skilled nursing or skilled rehabilitation care on a

daily basis while at the skilled nursing facility for any of the conditions with respect to which he was receiving inpatient hospital services prior to transfer to the extended care facility, as required by section 1814(a)(2)(C) of the Act.

The physician's orders at the time of admission to the skilled nursing facility show that H was allowed out of bed in a chair with restraints and was to be encouraged to walk with a cane. A semisoft diet and some orally administered medication were also prescribed. The nurses' notes indicate that H seemed to be confused and not entirely aware of his surroundings. He was able to walk with help and feed himself very slowly. Urinary incontinence was noted and an incontinence bag was applied. No other significant notations appear in either the Doctor's Orders or the Nurses' Notes until November 17, 1977, when H began to cough frequently. At that time the medication was changed and a catheter was inserted. In addition, the Doctor's Orders show that all medications prior to November 18, 1977, were oral and that no intramuscular injections were ordered or given until after that date. Subsequently H's condition became increasingly aggravated and genito-urinary infection and impending pneumonia were added to the diagnosis.

The services required by H and the services he actually received upon his admission to the skilled nursing facility on October 18, 1977, and for several weeks thereafter until November 18, 1977, were supportive in nature and therefore specifically excluded from coverage by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act. It was not until 1 month after H's admission to the skilled nursing facility that his condition required the supervision of an individual skilled in nursing, and such skilled services as intramuscular administration of medication were performed. Undoubtedly H's condition changed on November 18 and skilled nursing care was required thereafter. However, these services were not required within the 14 day period after transfer from the qualifying stay for the treatment of any of the conditions with respect to which he was receiving inpatient hospital services but for treatment of pneumonitis he had contracted as well as a genito-urinary infection and anemia.

Accordingly it is *held*, coverage for the care and services furnished by the skilled nursing facility is precluded for the period from the date of admission to November 18, 1977, by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act since neither skilled nursing nor skilled rehabilitation services were required and the primary purpose of the services furnished was to assist him in meeting the activities of daily living. *Further held*, payment for the skilled nursing services furnished by the skilled nursing facility beginning November 18, 1977, is also precluded since such services were not for the treatment of any of the conditions for which he was receiving inpatient hospital services prior to transfer to the skilled nursing facility, as required by section 1814(a)(2)(C) of the Social Security Act.

(X—Refer to SSR 70–46)

SECTIONS 1814, 1861, and 1862—HOSPITAL INSURANCE BENEFITS—LEVEL OF CARE IN SKILLED NURSING FACILITY—CLAIMANT NOT RECEIVING SKILLED NURSING OR SKILLED REHABILITATION SERVICES ON A DAILY BASIS

42 CFR 405.1101(d) HCFAR 79–36a*

An individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act entered a skilled nursing facility after a qualifying hospital stay for treatment of a cerebral vascular accident. The residual effect of her accident was manifested chiefly by difficulty in walking. She received all medication orally, spent much of her time out of bed each day, fed herself and cared for her own personal needs with little assistance. *Held,* coverage for the services provided in the SNF is precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, when the primary purpose of the services was to assist the patient in her daily living activities.

N, an individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was hospitalized from August 31, 1976, to September 7, 1976, as a result of a cerebral vascular accident, with aphasia and some hemiparesis on the left side. On the latter date she entered the O Convalescent Home, a skilled nursing facility, where she remained until December 1, 1976. Coverage for services furnished at the O Convalescent Home was denied on the basis that the level of care provided N did not constitute skilled nursing or skilled rehabilitation services, or covered posthospital extended care services within the meaning of section 1861(i) of the Social Security Act, but were custodial in nature and, therefore, excluded from coverage under section 1862(a)(9) of the Act. This case was before the Appeals Council because N protested this denial.

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including posthospital extended care services for up to 100 days during any spell of illness. Section 1861(i) of the Act provides, as pertinent here, that the term "posthospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. Payment may be made for such services only to providers thereof, if, among other conditions not here pertinent, a physician certifies that:

> . . . such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to

* Cases decided by the Appeals Council of the Bureau of Hearings and Appeals, Social Security Administration, representing the final decision of the Secretary, are identified throughout the publication by a suffix "a" after the ruling number.

transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services. . . . (Section 1814(a)(2)(C)).

Section 1861(j) of the Act provides, as pertinent here, that the term "skilled nursing facility" means an institution which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Section 1862(a) of the Act provides that:

Notwithstanding any other provision of this title, no payment may be made under part A or part B [supplementary medical insurance] for any expenses incurred for items or services:

* * * * *

(9) Where such expenses are for custodial care.

The issue to be decided in this case is, therefore, whether the services furnished N by the O Convalescent Home, a skilled nursing facility, from September 7, 1976 to December 1, 1976, constitute covered posthospital extended care services within the meaning of section 1861(i) of the Act, or whether such services are precluded from coverage by the "custodial care exclusion" in section 1862(a)(9) of the Act.

The hospital discharge summary states that N did well in the hospital, that studies failed to reveal any serious abnormality other than that associated with the aging process and what would be expected following a cerebral vascular accident. The report also states that N had no more residual defect than was apparent at discharge, "which is really very minimal and manifested primarily by difficulty with walking." The "Nurse's Record" and "Monthly Medicine Record" relating to N's stay at the O Convalescent Home reveal that she spent much of her time out of bed walking around. She received oral medications, and was capable, with some assistance, of dressing and feeding herself and taking care of her personal hygiene. During her entire stay at the skilled nursing facility, she was visited by her attending physician on no more than three occasions.

Assistance to a patient in taking oral medications cannot be classified as a skilled service merely because it is performed by trained medical or licensed nursing personnel. For example, a patient can normally follow the instruction given and take oral medication prescribed by a physician. Consequently, the administering of such medication by a nurse to a patient, who is unable to perform the service herself, does not change the nature of the service from a nonskilled to a skilled service. Similarly, periodic visits by a physician to a patient do not, alone, justify a finding that the care furnished an individual is skilled care. Even though, in an institutional setting, the services of a physician may be readily available, the general pattern is for the physician to visit a patient only periodically, delegating

to the attendant responsibility for keeping, where necessary, close watch over the patient for changes in condition requiring immediate medical attention. Coverage under title XVIII for services provided in a skilled nursing facility is basically dependent on whether the *primary* purpose of the care is to provide daily "skilled nursing or skilled rehabilitation services." The important factor is the degree and extent of the skilled professional services an individual *requires* and *receives* while a patient in a skilled nursing facility.

The level of care provided N did not constitute daily skilled services within the meaning of section 1814(a)(2)(C), or covered posthospital extended care services within the meaning of section 1861(i) of the Social Security Act. The claimant required and received services which were primarily supportive or custodial in nature and thus excluded from coverage under section 1862(a)(9) of the Social Security Act.

Accordingly, it is the decision of the Appeals Council that coverage is denied for the services provided to N by the O Convalescent Home, a skilled nursing facility, during the period September 7, 1976 through December 1, 1976.

(X—Refer to SSR 70–47a)

SECTION 1861(e)—HOSPITAL INSURANCE BENEFITS—EXCLUSION OF SKILLED NURSING FACILITY FROM THE TERM "HOSPITAL"

42 CFR 405.101 and 405.120 HCFAR 79–37

A Part A hospital insurance beneficiary under title XVIII of the Social Security Act required emergency hospitalization for injuries resulting from a fall and was placed in a participating skilled nursing facility located on the hospital premises, because bed space was not available in the hospital. *Held,* since her services were furnished by a participating skilled nursing facility not meeting the definition of a "hospital" within the meaning of section 1861(e) of the Act, they did not constitute inpatient hospital services but rather skilled nursing services. *Further held,* since her admission to the skilled nursing facility was not preceded by an inpatient hospital stay of at least three consecutive days, as required by section 1861(i) of the Act, program payment cannot be made for such services.

M, an individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, fell, sustaining a fractured wrist, sprained knee, and a fractured pelvis. She was treated in the emergency room of the L Memorial Hospital. In need of immediate hospitalization, M was admitted to the L Extended Care Unit because no rooms were available in the L Memorial Hospital. M remained in the skilled nursing facility for 26 days, beginning February 5, 1977. Payment to the L Extended Care Unit on M's behalf for the care and services furnished her there was denied on the basis that the skilled nursing facility, while qualified as a participating skilled nursing facility, did not meet the requirements of a hospital-provider of emergency services under section 1814 of the Social Security

Act. M has protested this determination, contending that the services furnished her by the L Extended Care Unit were in fact covered inpatient hospital services within the meaning of section 1861(b) of the Act, and not posthospital extended care services.

The issue to be resolved in the instant case is whether the services rendered by the skilled nursing facility were covered "inpatient hospital services" or "post-hospital extended care services" for purposes of title XVIII of the Social Security Act.

The facts in the present case show that many facilities of the L Memorial Hospital and the L Extended Care Unit are shared by both and that the same administrators control both units. The L Extended Care Unit is a participating skilled nursing facility (as a distinct part of the L Memorial Hospital). Therefore, it cannot participate as a "hospital" within the meaning of section 1861(e) of the Act. In addition to listing a number of requirements (not here involved) which an institution must meet in order to participate as a "hospital" in the health insurance program, section 1861(e) further defines a hospital as any institution which is *not* primarily engaged in providing services as a "skilled nursing facility" within the meaning of section 1861(j)(1)(A) of the Act. It is accordingly *held* that the services provided M by the L Extended Care Unit did not constitute "inpatient hospital services" as defined in section 1861(b) of the Social Security Act.

The facts also show that M's admission to the L Extended Care Unit was an emergency measure. Pursuant to section 1814(d) of the Act, an institution which has not met all the conditions, or has not been accepted to become a "participating hospital," may be paid under the program for emergency services it has furnished. It must, however, meet the requirements of a "hospital," as defined in section 1861(e) cited above. Since that section specifically excludes a participating skilled nursing facility from the definition of the term "hospital," M is not entitled to have program payment made on her behalf under section 1814(d), even if her admisison was an "emergency" as contemplated under the Act.

There remains the question whether the services furnished M by the nursing care unit constitute covered "post-hospital extended care services" within the meaning of section 1861(i), so that program payment may be made for services on M's behalf. That section provides, in pertinent part, that the term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. It was admittedly a disadvantage to M that she could not obtain a bed in the L Memorial Hospital. However, since M's admission to the L Extended Care Unit was not preceded by an inpatient hospital stay of at least 3 consecutive days, as required by section 1861(i) of the Act it is *further held,* that payment may not be made on her behalf for the services she received at the L Extended Care Unit beginning February 5, 1977.

(X—Refer to SSR 70–35)

SECTION 1861(i)—HOSPITAL INSURANCE BENEFITS—3-CONSECUTIVE DAY HOSPITAL STAY REQUIREMENT PRIOR TO TRANSFER TO SKILLED NURSING FACILITY

42 CFR 405.120(c) HCFAR 79–38

An individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, is given emergency treatment in a hospital for a broken ankle and secondary shock, then transferred *on the same day* by ambulance to a skilled nursing facility under orders from the attending physician at the hospital. A specialist enlisted by her family later diagnosed her condition as a stroke and she was returned to the hospital. *Held,* payment may not be made on her behalf for care and services furnished by the skilled nursing facility because she was not an inpatient of a hospital for at least 3 consecutive days before her discharge from the hospital in connection with such transfer, as required by section 1861(i) of the Social Security Act. The 3-day hospital stay requirement applies even though the decision to discharge the beneficiary on the same day she was admitted to the hospital may have been inappropriate from a medical viewpoint.

L, an individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was taken in an ambulance to a hospital, after she fell on the boardwalk at a beach resort. The attending physician on the hospital staff diagnosed L's case as a broken ankle and secondary shock, and placed her ankle in a cast. After ordering L placed under restraint, he had her transferred the same day to the N Nursing Home, a skilled nursing facility, because L's husband, age 84, could not look after her at home, and her children lived too far away for her to travel in her condition. When L failed to recover the full use of her senses, her family became apprehensive and enlisted the services of a specialist, who diagnosed L as having suffered a stroke. After being confined in the skilled nursing facility for almost 30 days she was taken back to the hospital, where she died 2 days later.

The claimant, L's son, filed a claim for reimbursement under title XVIII of the amount he paid the N Nursing Home for the services provided L by that facility. The claim was denied on the basis that L had not met the 3-consecutive day hospital stay requirement in section 1861(i) prior to her admission to N Nursing Home.

Section 1861(i) of the Social Security Act, as amended, provides in pertinent part that the term "post-hospital extended care services" means extended care services furnished an individual "after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer."

While it is not here argued that L remained in the hospital 3 days before her transfer to the skilled nursing facility as required by section 1861(i) of the Act, it is contended that her discharge was not ordered pursuant to a "correct" medical determination that she be discharged, and therefore, since the medical determination was incorrect, the 3-day limitation is inoperable.

The plain words of the statute in their ordinary meaning are clear and do not, under recognized rules of statutory construction, permit such a

reading. This would, in effect, superimpose an additional and significant limitation on the 3-day condition of entitlement to post-hospital care in section 1861(i) of the Act. There was no apparent intent on the part of Congress to limit the 3-day requirement to cases where the discharge of the patient is shown to be medically correct.

Since L was not a hospital inpatient for 3 days before her transfer to the N Nursing Home, as required by section 1861(i) of the Social Security Act, it is accordingly *held* that payment may not be made on L's behalf for the extended care services provided by the N Nursing Home.

(X—Refer to SSR 70–36)

SECTIONS 1812(a) and 1861(i) (42 U.S.C. 1395ff)—HOSPITAL INSURANCE BENEFITS—POST-HOSPITAL EXTENDED CARE SERVICES—100-DAY LIMITATION

42 CFR 405.120 HCFAR 79–39

A claimant for hospital insurance benefits, following her qualifying hospital stay, was admitted in May 1976 to a participating skilled nursing facility for treatment of cerebral arteriosclerosis. She remained in the facility as a patient until January 1977, receiving the same care from admission until her discharge. The patient was bedridden, asphasiac, had no sensation, required constant use of catheters, and special equipment to remove accumulations of liquid in her chest, use of oxygen equipment, and regular injections and antibiotics. *Held,* the claimant required and received skilled nursing care during her entire stay in the skilled nursing facility; however, payment may be made on her behalf only for the 100-day period beginning May 1976, the maximum number of days authorized by section 1812 of the Act during any spell of illness.

H, a claimant for hospital insurance benefits, was hospitalized on May 21, 1976, for cerebral arteriosclerosis and transferred on May 24, 1976, to a participating skilled nursing facility. She remained there until January 28, 1977.

Medical evidence indicated that during this period H was bedfast; that it was necessary at all times to use a catheter for incontinence; that she was unable to talk or make requests for medical care or other attention; and that she was constantly under the care of nurses, nurses' aides, and her treating physician, who saw her every 2 or 3 days. In addition, she required frequent tracheal aspiration due to a very poor gag reflex. An aspirator and oxygen tent were kept in her room at all times.

The Utilization Review Report of June 17, 1976, indicates that H's behavior was nonresponsive, that she was aphasiac, could not hear, had no sensation, required a catheter, and was bedridden. It further showed that H could not ambulate and was unable to dress or feed herself.

The nurses' notes indicate that in addition to the daily catheter attention, the claimant suffered from accumulation of liquid in her chest, which required suction machines to relieve gagging, and use of oxygen, injections of Terramycin, and prescriptions for antibiotics.

Under the above factual situation, the issue to be determined is whether payment may be made under the hospital insurance program for post-hospital extended care services rendered to H during the period of June 20, 1976, through January 28, 1977. (Payment was made for the services she received from May 24 through June 19, 1976, but was denied for the services she received after that date on the ground that they did not constitute skilled nursing care, or other skilled rehabilitation services, but instead were for her protective care and observation, for her activities of daily living, and for her nutritional needs and medication.) This, in turn, depends upon whether the care received by H was of the level required to meet the criteria for extended care benefits.

An individual entitled to hospital insurance benefits under section 1812 of title XVIII of the Social Security Act (42 U.S.C. 1395ff) is eligible to have payment made on his behalf to a participating skilled nursing facility for up to 100 days of extended care services furnished to him in a spell of illness, if he was transferred to such facility generally within 14 days after discharge from a hospital in which he was an inpatient for not less than 3 consecutive days.

Under the Act, benefits are payable for treatment in a skilled nursing facility if medically necessary skilled services are furnished on a daily basis; i.e., an overall level of care is provided which must be done by or under the general supervision of trained medical or technical personnel to assure the safety of the patient and achieve the medically desired result, if the skilled services, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis, and if the services are for the continued treatment of a condition for which he received inpatient hospital services or for a condition which arose while he was in a skilled nursing facility receiving care for a condition for which he received inpatient hospital services. A service would not be classified as a skilled service merely because it is performed by a trained medical or paramedical person. If the care can be safely and adequately self-administered or performed by the average nonmedical person without the supervision of trained medical personnel, or if the care consists only of assistance with the needs of daily life, it is mainly supportive care for which no benefit payment can be made.

Under the medical evidence herein, it is clear that H required and received a level of care covered by the Act. Her frequent urinary problems which required daily visits by doctor and nurse, the daily catheter attention, the relief from accumulation of liquid in the chest (which required use of special equipment), use of oxygen, injections, and antibiotics, attest to the complexity of H's treatment regimen and the fact that she did receive a level of care which was performed by and under the general supervision of licensed nurses. This care could not have been performed safely and adequately by a nonmedical person; neither would her safety have been assured in order to achieve the necessary results in her medical treatment.

Accordingly, it is *held* that payment may be made on behalf of H for post-hospital extended care services, but only for the period May 24 to September 2, 1976, the maximum 100-day total authorized by section 1812 of the Act during any spell of illness.

(X—Refer to SSR 71-35)

SECTIONS 1814(a)(2)(C) and 1861(i)—HOSPITAL INSURANCE—POST-HOSPITAL EXTENDED CARE—SERVICES LESS THAN SKILLED EXCLUDED FROM COVERAGE

42 CFR 405.310(g) and 405.1101(d) HCFAR 79–40

> Where an individual, entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, is admitted to a skilled nursing facility on August 12, immediately after a qualifying hospital stay, for continuing treatment of a stroke but is able to walk with little assistance, to bathe herself and to care for her own personal needs, and requires and received no therapy and little medication until September 18, when she suffers a second stroke, more than 30 days after she first entered the skilled nursing facility, *held*, payment on her behalf to the skilled nursing facility for the services furnished may not be made because she did not receive the required level of care (i.e., "skilled nursing care" or other skilled rehabilitation services) as required by section 1814(a)(2)(C) of the Act within a period of 14 days following her discharge from the hospital as required by section 1861(i) of the Act.

D, an individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was hospitalized, due to a stroke from August 9, 1977, to August 12, 1977. On August 12, she was transferred to the B Nursing Home, certified as a participating skilled nursing facility, where prior to her stroke she had been a permanent resident. Payment on her behalf to the skilled nursing facility for services furnished was denied on the basis that her condition did not require, nor did she actually receive, "skilled nursing or skilled rehabilitation care" within the meaning of section 1814(a)(2)(C) of the Act, below. They did not therefore constitute covered post-hospital extended care services. D has protested this decision.

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consist of entitlement to have payment made on his (her) behalf for post-hospital extended care services for up to 100 days during any spell of illness (benefit period). Section 1814(a)(2) of the Act provides, as pertinent here, that payment will be made for such services to providers thereof, only if a physician certifies that the services

> (c) . . . are or were required to be given because the individual needs or needed on a daily basis skilled nursing care or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the extended care facility or for a condition requiring such skilled nursing services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

Section 1861(i) of the Act defines the term "post-hospital extended care services" as

> extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer.

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For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 14 days after discharge from such hospital, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital; an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

The issue to be resolved in the instant case is whether or not D is entitled to coverage of the services furnished by the B Nursing Home for the period beginning August 12, 1977. In turn, this issue is dependent upon whether these services meet the definition of "post-hospital extended care services" in section 1861(i) of the Social Security Act.

The evidence in the instant case shows that D was able to be up and around in the skilled nursing facility to bathe herself and to go to the dining room for meals. It was not until after D suffered a second cerebral accident on September 18 that exercise, special therapy, supervision, and physician therapy were begun. From August 12 through September 17 D received neither skilled rehabilitation nor skilled nursing services. The only medication given to D during the period from August 12 through September 17 was analgesics for arthritic pains, maalox for epigastric pains, and a saline gargle for a slight sore throat.

Based on the evidence presented in this case, it does not appear that the services rendered D during the period August 12 to September 17, 1977, had to be performed by or under the supervision of a nurse. Therefore, it is *held* that such services did not constitute "skilled care on a daily basis," as required by section 1814 of the Act cited supra. Undoubtedly D's condition worsened on September 17, and skilled services may have been required thereafter. However, by that date, more than 14 days had elapsed since her discharge from the hospital on August 12. Since D did not receive the required level of extended care services as required by section 1814 (a)(2)(C) within 14 days of her discharge from the hospital, it is *further held* that coverage is denied for the services provided to D by the B Nursing Home for the entire period beginning August 12, 1977.

(X—Refer to SSR 70-59)

SECTION 1861(i)—HOSPITAL INSURANCE BENEFITS—EXTENDED CARE SERVICES—3-CONSECUTIVE-DAY HOSPITAL STAY REQUIREMENT

42 CFR 405.120(a) HCFAR 79–41

Where a hospital insurance beneficiary was admitted to a hospital on November 5; transferred to another hospital on November 7; and then transferred to a skilled nursing facility on November 8; *held*, the inpatient services furnished by the two hospitals encompasses 3 consecutive days prior to discharge, and thus the beneficiary met the prerequisite 3-consecutive-day hospital stay requirement contained in section 1861(i) of the Social Security Act and section 405.120(a) of the Regulations of the Health Care Financing Administration.

B, a hospital insurance beneficiary under part A of title XVIII of the Social Security Act was taken by ambulance to the R Hospital on November 5. While there she became unmanageable and on the advice of the attending physician was transferred to the S Hospital on November 7. The following day on November 8, B was transferred to the T Nursing Home, a skilled nursing facility. A claim for payment was filed for the extended care services furnished by the T Nursing Home, a skilled nursing facility participating as a provider of services under title XVIII of the Social Security Act.

Section 1861(i) of the Social Security Act provides, as pertinent here, that the term "post-hospital extended care services" means extended care services furnished an individual "after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer."

Section 405.120(a) of the Regulations of the Health Care Financing Administration (42 CFR 405.120(a)) provides, in part, for payment of extended care services only:

> . . . if he is admitted to such skilled nursing facility within the time specified after his discharge from a hospital in which he was an inpatient for not less than 3 consecutive calendar days . . .

It is clear that B was transferred to the skilled nursing facility within 14 days after discharge from the S Hospital. Thus the sole issue is whether B was an inpatient of a hospital for at least 3 consecutive days prior to her admission to the skilled nursing facility as required by section 1861(i) of the Act.

In this case B was an inpatient in the S Hospital for one day and an inpatient of the R Hospital on the two immediately preceding days. There is nothing in the Social Security Act or the regulations promulgated thereunder that requires the 3-day hospital stay to be at a single hospital. If, as in this case, the prior hospitalization was continuous for at least 3 consecutive days the requirement of section 1861(i) (supra) and section 405.120(a) of the Regulations is met. It follows that B met this requirement since she was an inpatient of a hospital for a total of 3 consecutive days.

(X—Refer to SSR 71–51)

SECTIONS 1814(a)(2)(C), 1861(k)(4), and 1862(a)(9)—HOSPITAL INSURANCE BENEFITS—SKILLED NURSING FACILITY—UTILIZATION REVIEW COMMITTEE'S FAILURE TO NOTIFY CLAIMANT OF FINDING—CUSTODIAL CARE EXCLUSION

42 CFR 405.120 and 405.166 HCFAR 79–42

Post-hospital services provided a hospital insurance beneficiary by a skilled nursing facility beginning June 14 were found to be daily skilled only until July 20, after which she required and received only routine care in addition to the administration of eye drops. The skilled nursing facility's utilization review committee did not certify as to the need for other than routine, custodial care after July 20. However, the beneficiary was not notified promptly of this change of status. *Held*, the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, as amended, precludes coverage for the services provided after July 20, notwithstanding the utilization review committee's failure to meet the requirement of prompt notification in section 1861(k) of the Act. Such failure does not obviate the necessity of making a finding as to whether such services were in fact covered under the law.

The insurance benefits provided an individual under section 1812(a) of the Social Security Act consist of entitlement to have payment made on his behalf for certain hospital, post-hospital, and medical services, including post-hospital extended care services up to 100 days during any spell of illness.

M, an 85-year-old hospital insurance beneficiary, was admitted to the O Convalescent Home, a skilled nursing facility, on June 14, after a qualifying hospital stay. Her condition on admission was diagnosed as arteriosclerosis, heart disease, senile dementia and glaucoma, left eye, the same conditions for which she was treated in the hospital. Payment was made to the facility on M's behalf for the extended care services furnished her for the period from June 14 through July 20 and that period is not in issue. The facility's Utilization Review Committee did not certify that *further* "extended care" services would be required after that date. Coverage was denied for the services furnished M for the period beginning July 21, on the basis that they did not constitute skilled nursing care or skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, as required by section 1814(a)(2)(C) of the Act, but were instead custodial and therefore excluded from coverage pursuant to section 1862(a)(9) of the Act.

Section 1814(a)(2) of the Act provides, in pertinent part, that:

. . . payment for services furnished an individual may be made only to providers of services . . . and only if—

* * * * *

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed skilled nursing care or other skilled rehabilitation services, which as a practical

matter can only be provided in a skilled nursing facility on an inpatient basis for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services . . .) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services: * * *

Section 1862(a) of the Act provides, as pertinent here, that:

Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

* * * * *

(9) where such expenses are for custodial care;* * *

The issue to be decided in this case, therefore, is whether the services furnished M by the O Convalescent Home, a skilled nursing facility, from July 21 through September 21, constituted skilled nursing care or skilled rehabilitation services, on a daily basis, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, within the meaning of section 1814(a)(2) cited *supra*, or whether such services are precluded from coverage by the "custodial care" exclusion in section 1862(a)(9) of the Act, *supra*.

The evidence shows that during this period the attending physician's orders were for a soft diet, and bed rest, with bathroom privileges. M was ambulatory and was allowed to sit up in a chair as much as she could tolerate it. No physical therapy or rehabilitation of any type was prescribed. On July 21 the attending physician ordered continuation of M's eye medication and stated that M "may leave with family." On July 22 M left the Home with a friend and returned with no apparent difficulty. On July 23 she received medication for leg pains. On July 28 she left the Home again, with a friend. Throughout this period, M's most urgent need was the administration of eye drops.

M's guardian argued that he was not promptly notified by the Home of the fact that extended care services were not required after July 20. He urges that, had he been so informed, he could have made other arrangements for M's care. It is unfortunate that he was not so notified, but this failure does not alter the basic requirements of the Social Security Act or create a right to coverage where as a matter of law none exists.

Section 1861(k) of the Social Security Act provides, as pertinent here, that every qualified skilled nursing facility must have a utilization review committee, and among other things, the utilization review plan must provide:

* * * * *

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such individual during a continuous period of extended duration, as of such days of such period . . . as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

This requirement of prompt notification, however, is a prerequisite to certification of the skilled nursing facility as a provider of services under title XVIII and the failure by the O Convalescent Home to comply with it is relevant only to the issue of the Home's continued certification as a participating provider. Such failure does not serve to justify coverage for a service (i.e., custodial care) which is specifically excluded by the statute.

The function of a utilization review committee is to afford the skilled nursing facility a mechanism for appraising medical care by a peer review of the attending physician's services. While consideration should be given to the recommendation made by a utilization review committee, or to the committee's failure to act or to follow prescribed procedures in a particular case, the final decision with respect to coverage under the program must involve a finding as to the level of care which was medically required and which was rendered the individual. In this case, whether or not the utilization review committee of the O Home followed prescribed procedures under section 1861(k) of the Act cited above, the record clearly supports the conclusion that the services furnished M after July 20 were not skilled services on a daily basis.

In considering whether services rendered to an inpatient are skilled or not, attention must be focused primarily upon the specific type of service provided the claimant and whether these services were such that they had to be performed by skilled medical or paramedical personnel. However, a service would not be classfied as a skilled service even though performed by a trained medical or paramedical person, if it can be performed safely and adequately by the average lay person after appropriate instructions.

The evidence in this case shows that M neither required nor received skilled care on a daily basis at any time after July 20. Accordingly, it is *held* coverage is denied for the care furnished to M commencing July 21, because such care was custodial and therefore specifically excluded from coverage under section 1862(a)(9) of the Social Security Act.

NOTE: Section 213 of Public Law 92–603 contained a provision which limits the liability of a Medicare beneficiary where medicare coverage is denied by virtue of section 1862(a)(1) or (9) and the beneficiary, acting in good faith, did not know or have reason to know that the services would not be covered. This provision is contained in section 1879 of the Act and is applicable to services rendered after October 30, 1972.

(X—Refer to SSR 71–8)

SECTION 1862(a)(9)—CUSTODIAL CARE EXCLUSION FROM COVERAGE—POST-CATARACT SURGERY SERVICES FURNISHED AT SKILLED NURSING FACILITY

HCFAR 79–43a

Where a Part A beneficiary, at his doctor's suggestion after cataract surgery, entered a skilled nursing facility to receive postoperative care and assistance pending receipt of his cataract lenses for his operated eye, because of the lack of the necessary facilities at his hotel residence, *held* payment to the skilled nursing facility precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, when skilled nursing services or other skilled rehabilitation services were not required and the primary purpose of the services furnished was to assist him in his daily living activities.

The general issue in this case is whether the services provided for the claimant by the N Convalescent Home, a skilled nursing facility, were custodial in nature and thereby excluded from payment under section 1862(a)(9) of the Social Security Act.

The record reveals that the claimant, age 65, was hospitalized for a right eye cataract extraction in the S Hospital from October 3, 1976 to October 10, 1976, when he was discharged and entered the N Convalescent Home. He remained in the skilled nursing facility until November 10, 1976, incurring total charges of $454.00.

The Medicare intermediary's medical advisory panel, a group composed of physicians, unanimously decided that the claimant's entire stay in the skilled nursing facility was for custodial care and excluded from coverage under the Medicare program.

The Health Care Financing Administration determined initially and upon reconsideration that the claimant received care in the skilled nursing facility to assist him with his activities of daily living and that this care is considered "supportive" or "custodial" and, therefore, specifically excluded from coverage.

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including post-hospital extended care services for up to 100 days during any spell of illness. Payment may be made for services furnished an individual only to providers of such services if, among other exceptions not here pertinent, a physician certifies that the services;

. . . are or were required to be given because the individual needs or needed on a daily basis skilled nursing . . . or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services. (Section 1814(a)(2)(C)).

Section 1861(h) of the Act provides, as pertinent here, that the term "extended care services" means items and services furnished to an inpatient of a skilled nursing facility, including nursing care provided by or under the supervision of a registered professional nurse. Section 1861(j) of the Act provides, as pertinent here, that the term "skilled nursing facility" means . . . an institution . . . which—

> (1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Section 1862(a) of the Act provides that:

> Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
>
> * * * * *
>
> (9) where such expenses are for custodial care.

The Appeals Council believes that "custodial care" is that type of care which is designed essentially to assist an individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, and feeding, preparation of special diets, and supervision of medication which can usually be self-administered and which do not entail or require the continuing attention of trained medical or paramedical personnel.

The claimant received from his ophthalmologist a typewritten instruction form regarding his postoperative care and indicating, in part, as follows:

> Today you are discharged from the hospital after having your cataract surgery. There is some information that you will need to help you to a most successful recovery. The following is a sketch of your convalescence . . . After your discharge your activities will be limited as during your hospital stay . . . no bending, lifting, avoid coughing and straining, do not wash your hair, no showers: . . . in other words, take it easy.
>
> You are to take home from the hospital with you the green shield, scotch tape and small tube of ointment which are in the tray at your bedside. Every night the ointment should be applied and the shield should be applied with scotch tape (as was done by the nurses in the hospital). (To apply the ointment, pull the lower lid down gently and place a small strip of the ointment inside the lower lid. Do not touch the upper eyelid.) In the morning, the shield should be removed, the eye cleansed GENTLY with cotton and warm water. During the day, dark glasses should be worn but the eye should be kept open.

It appears that after cataract surgery this ophthalmologist customarily discharges a patient to his home with the above instructions. A patient in this situation does not require skilled services on a daily basis which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis. He does not need "skilled nursing care" since he can apply the ointment and shield by himself.

The doctor stated:

> I do not agree that this was just 'custodial' care. [J] has a cataract in the left eye which gives him a poor vision. This poor vision prevented [J] from taking care of himself after the cataract surgery until he received his cataract lenses for the operated eye.
>
> I wish you would reconsider his claim. It was my suggestion that he be in a nursing home for the proper care and the installation of the eye ointment at night.

The claimant testified at the hearing that for 9 years he has lived alone in a second floor hotel room without kitchen facilities or running water and that he eats his meals in restaurants. In answer to the question why he went to the nursing home instead of going back to the hotel, the claimant answered as follows:

> That's simple that is. The day the doctor told me that I was to go to the hospital, he says, well then you need a home for awhile and he mentioned to the nurse and they said the (N Home) has just started up . . .

It is clear from the above that the primary purpose of the care furnished the claimant by the N Convalescent Home was to assist him in meeting the activities of daily living and that neither skilled nursing services nor skilled rehabilitation services were needed.

An examination of the records of the skilled nursing facility does not lead the Appeals Council to a different conclusion. The claimant was ambulatory. A nurse put ointment in his eye each night and taped a shield over his eye. She also put drops in his eyes four times a day. These services could be adequately performed by the claimant himself and, therefore, are found to be custodial services.

Accordingly, after careful consideration of the entire record, the Appeals Council believes, and so finds, that the care received by the claimant in the N Convalescent Home was custodial in nature and, therefore, is specifically excluded from coverage by section 1862(a)(9) of the Act.

Consequently, it is the decision of the Appeals Council that these services are not covered under the hospital insurance benefits program established by title XVIII of the Social Security Act.

(X—Refer to SSR 69-52a)

SECTION 1862(a)(9).—CUSTODIAL CARE EXCLUSION FROM COVERAGE—LONG TERM POSTHOSPITAL CARE FOR LOW BACK STRAIN AND OSTEOARTHRITIS—SERVICES FURNISHED AT SKILLED NURSING FACILITY

HCFAR 79–44a

A 92-year-old Part A beneficiary, after hospitalization for a fall in her home, entered the hospital's skilled nursing facility for long term care of acute low back strain, osteoarthritis and generalized arteriosclerosis. She was ambulatory, with some assistance; she received oral medication; and required general care, but because of age and impaired vision, it was felt nursing services should be available to her at all times. *Held,* payment to the skilled nursing facility is precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, since skilled nursing services or other skilled rehabilitation services were not required and the primary purpose of the services furnished was to assist her in her daily living activities.

T, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act fell at home, where she was living alone, injuring her back and on August 5, 1977, was admitted as an inpatient to the D Hospital. On August 15, 1977, she was transferred to the hospital's skilled nursing facility unit for long term care. The issue before the Appeals Council is whether the claimant received "post-hospital extended care services," within the meaning of title XVIII of the Social Security Act, during all or part of the period, August 15 through November 22, 1977.

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consists of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including posthospital extended care services for up to 100 days during any spell of illness.

Section 1814(a) of the Act provides, in pertinent part, that payment for services furnished an individual may be made only to providers of services and only if:

(2) a physician certifies . . . that—

* * * * *

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed skilled nursing care or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis or any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

Section 1861(h) of the Act provides as pertinent here:

> The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and . . . by such skilled nursing facility—
> (1) nursing care provided by or under the supervision of a registered professional nurse . . .
>
> * * * * *
>
> (3) physical, occupational, or speech therapy furnished by the skilled nursing facitily or by others under arrangements with them made by the facility;
> (4) medical social services;
> (5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients; * * *

Section 1861(j) of the Act provides as pertinent here:

> The term "skilled nursing facility" means . . . an institution . . . which—
> (1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured,, disabled, or sick persons . . .

Section 1862(a) of the Act provides in pertinent part:

> Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services—
>
> * * * * *
>
> (9) Where such expenses are for custodial care.

The facts in this case show that the admitting diagnosis to the skilled nursing facility were "acute low back strain, osteoarthritis, and generalized arteriosclerosis." The record indicates further that the claimant had defective vision to the extent that she was unable to read. The "Doctor's Order Sheet" contains an entry dated August 11, 1977, that she was permitted to walk "with help." By September 15, 1977, she was to be allowed to walk by herself with a cane but help was to stand by and on October 15, 1977, the doctor instructed that she could leave the building with a reliable friend.

The "Nurses' Notes" accompanying charts reflect that the patient, with varying degrees of assistance, was ambulatory throughout the period in question. She walked in the hall, visited other patients, and was even permitted to leave the facility on occasion. Medication for her back pain was taken orally and she was graded "Good" for her appetite and sleep. Her diet was shown as "regular" and her care as "general."

The Administrative Assistant and Treasurer of the D Hospital, although testifying on behalf of the claimant at the hearing, stated that the claimant's diagnosis did not require skilled nursing services but that because of her

age (92) and impaired vision it was felt nursing services should be available to her at all times.

In the opinion of the Appeals Council, the record supports a conclusion that the claimant, who was partially blind had reached a point, precipitated no doubt by the mishap at home, where she required some assistance in carrying on the physical activities of daily living. This included such activities as getting in and out of bed, bathing, dressing, and taking oral medication. The record does not show that the claimant was receiving, during the period in question, skilled nursing services or treatments which required the services of trained medical or paramedical personnel on a daily basis. The medications she received could be self-administered or given by a lay person.

The evidence of record does not, therefore, reflect a situation where the primary purpose of the claimant's admission to the facility was because she needed skilled services which could be performed only by trained medical and paramedical personnel. The primary need was for supportive care in daily living which constitutes "custodial" and thus noncovered care under section 1862(a)(9) of the Act, and the Appeals Council so finds.

It is the decision of the Appeals Council that the services furnished the claimant by the skilled nursing facility of D Hospital during the period August 15, 1977, through November 22, 1977, are not covered under title XVIII of the Social Security Act.

(X—Refer to SSR 69–53a)

SECTION 1862(a)(9)—CUSTODIAL CARE EXCLUSION FROM COVERAGE—POSTHOSPITAL CARE OF LEG IN CAST—SERVICES FURNISHED AT SKILLED NURSING FACILITY

HCFAR 79–45a

Where an 83-year-old Part A beneficiary with a chronic heart condition entered a skilled nursing facility after hospitalization for treatment of a fractured ankle, to receive further care while her leg was in a cast, and who required intermittent skilled nursing services during flareups of her heart condition, *held*, payment to the skilled nursing facility precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, where skilled nursing services or other skilled rehabilitation services which as a practical matter could only be provided in a skilled nursing facility on an inpatient basis were not required on a daily basis and the primary purpose of the services furnished was to provide routine assistance and care until she could walk again.

The record shows that W, who was born in November 1905 was admitted to the M Hospital on October 19, 1976, and that she remained in the hospital until December 15, 1976, when she was transferred to the T Nursing Center, a skilled nursing facility. The claimant remained in the skilled nursing facility until January 28, 1977.

The issue before the Appeals Council of the Social Security Administration is whether the claimant received "posthospital extended care services," within the meaning of the Social Security Act, during all or part of the period December 15, 1976, to January 28, 1977.

The hospital discharge record signed by her physician on December 15, 1976, indicated:

> This patient was admitted to the hospital on 10–19–76, after falling down in her garden and fracturing her left ankle with a fracture through the lower end of the tibia. This fracture was misplaced but was reduced and an application of a low cast, feeling like it would not necessarily in this case immobilize the knee.
>
> The patient was put to bed and remained in bed for several days and got along fine. She had no difficulty whatsoever and no pain or discomfort. This patient has also suffered from a coronary occlusion and also has cholecystolithiasis, which is not requiring any treatment at the present time. The cast was changed about ten days ago and re-x-rayed and the position was excellent, but did not show too much evidence of healing. At this stage she is being transferred to the nursing home to remain there for another couple of months and during this time she will be observed by the attending physician. No special treatment is required. She is being discharged as of today.
>
> CONDITION ON DISCHARGE: Very good.

The Nursing Care Plan prepared on December 15, 1976, includes the following:

> To teach Patient to walk again. Self-care—To teach patient to accept & live with existing condition.

Problems and Needs	*Approach*
Left leg in cast	Each day: Inspect skin under all edges of plaster-skin care do not use oily lotion on skin under cast Observe circulation Be aware of odors from cast—Report them Maintain proper position Report any degree of poor circulation Report any evidence of loss of feeling in toes or foot.
Has heart condition	Watch closely
Can feed self	Must be assisted at times—observe meals
May be up in wheelchair as condition permits	Elevate leg on pillow
Dyspnea & Cyanosis	O_2—PRN-record & report to head nurse

On the date of admission to the skilled nursing facility, the "Nurse's Notes" indicated: "Chief Complaint and Symptoms: Broken foot, left ankle * * * This patient fell in garden (at home) fracturing her right [sic] ankle with a fracture thru the lower end of the tibia. She has also

suffered from a coronary occlusion and also has cholecystolithiasis. She has a cast on left leg above knee to foot. She is very apprehensive concerning her present and past condition. Her family is very concerned . . . She prefers the family to stay with her as much as possible. Left leg elevated on pillow. Patient is very alert and answers question intelligently. Skin condition good."

Section 1812(a) of the Social Security Act provides, in pertinent part:

> The benefits provided to an indivdual by the insurance program under this part shall consist of entitlement to have payment made on his behalf . . . (subject to the provisions of this part) for—
>
> * * * * *
>
> (2) post-hospital extended care services for up to 100 days during any spell of illness . . .

Section 1814(a) of the Act provides, as here pertinent:

> . . . payment for services furnished an individual may be made only to providers of service * * * and only if—
>
> (2) a physician certifies (and recertifies, where such services are furnished over a period of time * * *) that * * *
>
> (C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed skilled nursing care or other skilled rehabilitation service which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was in the facility for treatment of the condition or conditions for which he was receiving inpatient hospital services . . .

Section 1861(h) of the Act provides, in pertinent part:

> The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and . . . by such skilled nursing facility—
>
> (1) nursing care provided by or under the supervision of a registered professional nurse;
>
> * * * * *
>
> (3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;
>
> (4) medical social services;
>
> (5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients; * * *

Section 1861(j) of the Act provides, in pertinent part:

> The term "skilled nursing facility" means . . . an institution . . . which—
>
> (1) is primarily engaged in providing to inpatients (A) skilled nursing

care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons . . .

Section 1862(a) of the Act provides, in pertinent part:

> Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
> (9) where such expenses are for custodial care.

The physician certified on December 15, 1976, December 28, 1976, January 27, 1977, and February 26, 1977, that the claimant required post-hospital extended care. The certifications gave no special reason except "continuous care needed: and the Appeals Council notes an inadvertent certification on February 26, 1977, when she no longer was in the institution. The Utilization Review Committee also made a report that the services were necessary because of her fractured tibia.

The doctor wrote a letter indicating, in pertinent part:

> My understanding in this case was that W was classified as custodial care which is incorrect for the following reasons: (1) She suffered a broken leg and was in a cast up to the middle of the thigh and could not get up to wait on herself at all. She was gotten up in a rolling chair with assistance from time to time during her stay in the nursing home. (2) This patient has been classified as a completely disabled person since suffering a coronary heart attack.
>
> (3) During her stay at the nursing home she had a flare-up of her heart condition and on two or three occasions went into a congestive heart failure requiring special medication and oxygen inhalation. In addition to the above conditions, this patient also suffers from cholelithiasis [sic] and marked arteriosclerosis generalized. A patient in this condition, and I am speaking as a physician, I cannot agree with any of the analysis of classification of the committee in certifying this patient custodial care. I most assuredly feel that part of the time that she was confined in the nursing home that she needed very skilled nursing care and I stated so to members of the family, that if she did not improve in twenty-four hours, that she would be transferred back to the hospital.

The record indicates, however, that the claimant, who was suffering and had been suffering from a heart condition for a number of years, was admitted into the hospital because of the fracture and not because of her heart condition.

According to the doctor's discharge summary there was no indication during her hospitalization, which lasted 57 days, that the claimant required any particular treatment for her heart condition, dyspnea or cyanosis but that she was admitted into the skilled nursing facility for further care with respect to her fractured leg, which while in excellent position, was healing slowly.

The "Nurse's Notes" indicate that the claimant received routine care in the skilled nursing facility from December 15, 1976, to January 3, 1977. Her medications were all oral and the care that she was receiving seems to have been routine. Outside visual inspection of the fracture site, the general care given her was the same care she received before and after her

hospitalization. During this period the "Nurse's Notes" show that she slept well and her appetite was good. Most entries indicated "routine care, a good night, up as desires, and no complaints." Although the doctor was called on admission, the notes do not indicate any visit prior to January 3, 1976, when during the early morning hours, the notes show that the claimant began coughing and complained of her chest hurting. The doctor prescribed an expectorant, nitroglycerin, and Equanil for her nerves. The entry on January 5 indicated that the patient appears to have "a lot of cold, routine care." Entries on January 8 included "slept well, quiet, good night, no complaints, routine care and ate well."

It appears, therefore, that the claimant was in the skilled nursing facility because she needed somewhat more supportive care following the fracture than she did while she was ambulatory. On January 3 she apparently contracted an upper respiratory infection and began to cough. This may perhaps have brought on a congestive seizure and it does appear that she received some skilled nursing services intermittently after January 3. The Appeals Council notes, however, that she was released only 4 days after she had another flare-up on January 24, 1977. Note is taken that the claimant's chronic conditions had been taken care of at her home under orders of the doctor, both before and after her hospitalization.

The Appeals Council notes that during the period December 15, 1976, to January 3, 1977, the claimant required no particular services for her heart and other conditions and, therefore, this period did constitute custodial care. Whatever skilled care was given the claimant as a result of these "flare-ups" did not occur at a time when she was receiving "post-hospital extended care services" within the meaning of the Act for any condition for which she had received inpatient hospital services prior to her transfer to the skilled nursing facility. The subsequent and limited periods during which the claimant received skilled nursing care occurred more than 2 weeks after she entered the skilled nursing facility, and while she was receiving custodial services within the meaning of the Act.

It is the opinion of the Appeals Council, therefore, that the primary reason for the claimant's stay was for supportive or custodial care arising out of fractures to the left leg and the intermittent skilled nursing services which she received were occasioned by a flare-up of a chronic heart condition which occurred while she was receiving the aforementioned custodial care.

It is, therefore, the decision of the Appeals Council that the services rendered to the claimant in the T Nursing Center, during the period December 15, 1976, to January 28, 1977, constituted custodial care within the meaning of title XVIII of the Social Security Act and, accordingly, these services are excluded from coverage.

(X—Refer to SSR 69-54a)

SECTION 1862(a)(9)—CUSTODIAL CARE EXCLUSION FROM COVERAGE—POSTHOSPITAL SERVICES FURNISHED AT SKILLED NURSING FACILITY

HCFAR 79–46a

Where a Part A beneficiary received services in a skilled nursing facility following her hospitalization for a fractured hip, was discharged therefrom and later readmitted, her doctor stating that her readmission was not for care related to her fracture but rather for her senility and that she did not require any specific nursing or physical therapy care but needed assistance in managing the walker which she used, because of intermittent syncopal episodes and confusion, *held* coverage of the services furnished in the skilled nursing facility is precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, when skilled services were not required and the primary purpose of the services furnished was to assist her in her daily living activities.

The record reveals that W, born in December 1905, was hospitalized with a fractured hip in D Hospital, from December 10, 1976, to January 6, 1977, when she was transferred to B Convalescent Hospital where she remained until February 4, 1977. She stayed with her daughter and son-in-law from that date until she was readmitted to the B Convalescent Hospital on February 12, 1977, where she remained until July 15, 1977. The B Convalescent Hospital did not become a participating skilled nursing facility under Medicare until February 6, 1977.

Section 1812(a) of the Social Security Act provides, in pertinent part:

> The benefits provided to an individual by the insurance program under this part [Part A hospital insurance benefits] shall consist of entitlement to have payment made on his behalf . . . for—
>
> * * * * *
>
> (2) post-hospital extended care services for up to 100 days during any spell of illness; . . . .

Section 1814(a) of the Act provides, as pertinent here, that payment for services to an individual may be made to providers of services but only if:

> (2) a physician certifies (and recertifies, where such services are furnished over a period of time . . .) that . . .
>
> (C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed skilled nursing care or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services; . . .

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Section 1861(h) of the Act provides, in pertinent part:

> The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and . . . by such skilled nursing facility—
> (1) nursing care provided by or under the supervision of a registered professional nurse;
>
> * * * * *
>
> (3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arranagements with them made by the facility;
> (4) medical social services;
> (5) such drugs, biologicals, supplies, appliances, and equipment furnished for use in the skilled nursing facility; as are ordinarily furnished by such facility for the care and treatment of inpatients;
>
> * * * * *

Section 1861(j) of the Act provides, in pertinent part:

> The term "skilled nursing facility" means . . . an institution . . . which—
> (1) is primarily engaged in providing to inpatients
> (A) skilled nursing care and related services for patients who require medical or nursing care, or
> (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons . . .

Section 1862(a) of the Act provides, in pertinent part:

> Notwithstanding any other provisions of this title, no payment may be made under Part A or Part B [supplementary medical insurance benefits] for any expenses incurred for items or services—
>
> * * * * *
>
> (9) where such expenses are for custodial care;
>
> * * * * *

W's physician made the necessary certifications that she required extended care services in January, February, March, and April 1977. However, on June 26, 1977, he wrote to the fiscal intermediary that "W's admission to the B Convalescent Hospital on February 12, 1977, was for custodial care. Her admission was not for care related to her fracture, but rather for her senility."

W's son-in-law, C, testified at a hearing that since W was unhappy at the rest home, he and his wife took her home with them on February 4, 1977. Normally, W lived alone and the record indicates that she subsequently returned to her own home about July 15, 1977, and remained there until her death in August 1977.

C further testified, in part, that ". . . she stayed with us a little over a week. In that time she wasn't able to stand or walk and would lose her

balance. She wet the bed several times and she was unhappy about that and she was unhappy with my wife and she got up-in-arms again, so on the 12th we took her back because my wife has an arthritic condition and she cannot, could not take care of a woman like that . . . Medically, you might say she was all right but she had to have a walker."

Subsequent to the hearing, a further statement was obtained from the physician which indicated his understanding that W was readmitted to the B Convalescent Hospital on February 12, 1977, because she was difficult to handle at home. He also stated that the patient was able to ambulate without assistance other than the walker and bear her full weight; that she did not require any specific nursing or physical therapy care; and that her main difficulty was that of "intermittent syncopal episodes and confusion." He indicated that there was no evidence of any significant injury to W after an alleged fall at the B Convalescent Hospital some time in February 1977.

A statement of charges covering W's entire stay at the B Convalescent Hospital indicates that from February 12 through May 31, 1977, the only charges, aside from room and board, were $14.30 for "Medications" and $50 for "Beauty Shop."

It appears clear from the doctor's statements in the record that he did not believe that W required skilled services in the period beginning on February 12, 1977, when she was returned to the B Convalescent Hospital. Nor is there any indication in the record that she was given any skilled medical attention during this period. To the contrary, the evidence suggests that this aged lady, not yet fully mobile because of her accident, required assistance in carrying on the activities of daily living. Thus, she might require assistance in such activities as walking, getting in and out of bed, bathing, dressing, eating and taking medication which could ordinarily be self-administered or given by an ordinary lay person. Such assistance might be required for a person of her age and condition and it might not be feasible, or even possible, for her to receive it outside of an institution. However, the evidence herein does not indicate that the primary purpose of W's stay at the B Convalescent Hospital, beginning on February 12, 1977, was because she needed skilled services on a daily basis which as a practical matter could only be provided in a skilled nursing facility on an inpatient basis. Rather, it is clear that the primary need was for supportive care in daily living, which is custodial and, therefore, not covered under Part A of title XVIII of the Social Security Act.

Therefore, it is the decision of the Appeals Council that the services provided to W during the period February 12 through July 15, 1977 are excluded from coverage.

(X—Refer to SSR 69–65a)

SECTION 1862(a)—HOSPITAL INSURANCE BENEFITS—EXCLUSION FROM COVERAGE—CUSTODIAL CARE

42 CFR 405.310(g) HCFAR 79–47

A Part A hospital insurance beneficiary under title XVIII of the Social Security Act entered a participating skilled nursing facility after 3 days as an inpatient in a participating hospital, allegedly in need of the administration of special feeding techniques requiring skilled nursing care. She received a regular diet on a regular basis given orally; the facility's records do not show that additional nutrients or fluids were given other than orally; all medication she received was given by mouth and was of the type which need not have been administered by medical or paramedical personnel; she spent much of her time out of bed each day, fed herself and cared for her own personal needs, and left the facility's premises and returned with no apparent difficulty. *Held*, payment on her behalf under title XVIII of the Act to the skilled nursing facility for the services provided is precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, when skilled nursing facility services were not required and the primary purpose of the services furnished was supportive in nature, to assist her in her daily living activities.

A, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act, was hospitalized for postoperative arthritis of the right hip and generalized arteriosclerosis from August 8, 1977 to August 11, 1977, at the M Hospital. On August 11, 1977, she was transferred to the H Nursing Home, a skilled nursing facility. She remained in the H Nursing Home until November 24, 1977. Coverage for the services furnished at the H Nursing Home was denied on the basis that the services rendered during her stay were "custodial" and, therefore, specifically excluded from coverage under section 1862(a)(9) of the Social Security Act. This decision has been questioned on the basis that A required and was administered "hyperalimentation" which is a medical procedure and requires, at the minimum, skilled nursing care. (Hyperalimentation is defined in Dorland's Illustrated Medical Dictionary (23d Edition) as "the ingestion or administration of a greater than optimal amount of nutrients.")

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including posthospital extended care services for up to 100 days during any spell of illness. Section 1861(i), of the Act provides, as pertinent here, that the term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. Payment for services to an individual may be made to providers of services but only if among other conditions not here pertinent, a physician certifies that the services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care . . . or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis for any of the conditions with respect to which he was

receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services. (Section 1814(a)(2)(C)).

Section 1862(a) of the Act provides that:

> Notwithstanding any other provisions of this title, no payment may be made under part A or part B [supplementary medical insurance] for any expenses incurred for items or services:
> (9) where such expenses are for custodial care.

* * * * *

The question to be decided in this case is whether the services furnished A by the H Nursing Home from August 11 to November 24, 1977, are covered or whether such coverage is precluded by the "Custodial care exclusion" in section 1862(a)(9) of the Act.

The controlling factor in determining whether or not the custodial care exclusion applies is the level of care and medical supervision that the patient requires and receives. Custodial care is the type of care which is designed essentially to assist an individual in the routine of daily living, e.g., assistance in walking, getting in and out of bed, bathing, use of toilet facilities, dressing, and feeding, and supervision of medication which could normally be self-administered and which does not entail or require the attention of trained medical or paramedical personnel. Where the primary purpose of the stay in the skilled nursing facility is to receive this type of care, then the services will be considered supportive or custodial.

The facts in the instant case indicate, based on the weekly graphic charts and daily nurses' notes covering the period in question and showing in detail the service and medication furnished by the skilled nursing facility to A, that she received a regular diet on a regular basis without additional nutrients or supplemental feedings. There are no indications that A was to have supplemental feedings or that fluids or other nutrients were given other than orally. Further, the records reveal that the medication A received was the type which can be given by mouth and need not be administered by or under the supervision of an individual having medical or paramedical training. Moreover, A spent much of her time out of bed each day; she showered regularly, unassisted and occasionally left the facility premises and returned, with no apparent problem.

Based on the facts in this case, although A may have received some services rendered by trained medical personnel, her primary need was for supportive care and the primary purpose of her stay at the H Nursing Home was to receive this type of care.

Accordingly, it is *held* that the services provided A in the H Nursing Home are not covered because the care A received while confined there was custodial in nature and excluded from coverage by section 1862(a)(9) of the Social Security Act.

(X—Refer to SSR 70–18)

SECTION 1862(a)(9)—HOSPITAL INSURANCE BENEFITS—EXCLUSIONS FROM COVERAGE—NURSING SERVICES LESS THAN SKILLED—SKILLED NURSING FACILITY

42 CFR 405.165 and 405.310(g) HCFAR 79–48

An 86-year-old hospital insurance beneficiary transferred to a skilled nursing facility from a hospital where she had been treated for fecal impaction. The admitting diagnosis to the skilled nursing facility was acute diarrhea and generalized arteriosclerosis. She was ambulatory, with assistance, and required only general care and oral medications. *Held,* payment on her behalf for care and services furnished by the skilled nursing facility is precluded by the "custodial care" exclusion in section 1862(a)(9) of the Social Security Act, since skilled services were not required and the primary purpose of the services furnished was to assist her in the activities of daily living.

R, an 86-year-old individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, was hospitalized for 1 week for removal of a fecal impaction. She was transferred to the N Nursing Home, a skilled nursing facility, on January 2, 1977, for further rehabilitation and good nursing care. On March 7, 1977, R was discharged from the skilled nursing facility. The N Nursing Home has filed a claim for payment for the services furnished R from January 2, 1977, through March 7, 1977.

The benefits provided an individual by the hospital insurance program in Part A of title XVIII of the Act consist of entitlement to have payment made to him or on his behalf for certain hospital and medical services, including posthospital extended care services for up to 100 days during a spell of illness (benefit period).

Section 1814(a) of the Act provides, in pertinent part, that payment for services furnished an individual may be made only to providers of services and only if:

> (2) a physician certifies . . . that—
> (C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis, skilled nursing care or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis for any of the conditions with respect to which he was receiving inpatient hospital services . . . prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services; . . .

Section 1861(h) of the Act provides as pertinent here:

> The term "extended care services" means the following items furnished to an inpatient of a skilled nursing facility and . . . by such skilled nursing facility—
> (1) nursing care provided by or under the supervision of a registered professional nurse . . .

* * * * *

(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients; * * *

Section 1861(j) of the Act provides as pertinent here:

The term "skilled nursing facility" means . . . an institution . . . which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons. . . .

Section 1862(a) of the Act provides in pertinent part:

Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

* * * * *

(9) where such expenses are for custodial care; . . .

The issue to be decided here is whether R received a covered level of "post-hospital extended care services," within the meaning of title XVIII of the Social Security Act, during all or part of the period January 2, 1977, through March 7, 1977. The facts in the instant case show that on the first required recertification date, January 15, 1977, R's physician certified that continued care in the skilled nursing facility was necessary to watch for recurrence of the impaction. On the next certification, February 14, 1977, he indicated that extended care was necessary for "Pleural effusion—watch for build-up of fluid in lungs. Check pulse for irregularity." The skilled nursing facility's records show that R was on a soft low-salt diet and was permitted to sit in a chair and to walk with an aide two to three times a day. On January 6, 1977, an order was written by R's physician for a form of digitalis and an order was given for a Fleet's Phospho soda followed by a Fleet's retention enema. There were no further orders given by the physician between January 6 and February 19, at which time an order was written for restraints of R's hands as necessary at night.

In a letter dated March 25, 1977, R's physician stated that she had "marked pulmonary emphysema in both lung fields and in my opinion it was necessary that she have extended care coverage so that any signs of impending failure could be attended to by a registered nurse who would be in attendance. Another condition she had was fecal incontinence which, of course, could be handled by ordinary nonskilled nursing care."

A skilled service is one which must be furnished by or under the general supervision of trained medical or paramedical personnel to assure the safety of the patient and to achieve the medically desired result. However, a service is not skilled merely because it is performed by trained medical or paramedical personnel. A service which can be safely and adequately self-administered or performed by the average rational, nonmedical person without the general supervision of trained medical or paramedical personnel, is a nonskilled service without regard to who actually provides the service.

The personal services provided R at the skilled nursing facility such as help in walking, assistance in bathing, dressing and preparation of diet do

not entail or require the daily attention of trained medical or paramedical personnel. The administration of oral medication pursuant to a physician's instruction could normally be accomplished without assistance from a trained individual. R's physician indicated that the services necessary for her condition could have been handled by nonskilled personnel.

Although the record shows that the claimant had pulmonary emphysema in both lung fields, it does not indicate that she received extensive treatment for the condition. Her physician indicated that it was necessary for R to have extended care services in order that she could be watched to determine if she showed signs of developing additional pleural effusion or of going into congestive heart failure.

R's arteriosclerotic heart condition appears to have stabilized prior to her admission to the skilled nursing facility. The records do not indicate that she was experiencing any difficulties with respect to her heart condition. In the absence of records to show that R was experiencing difficulty with her heart condition or that indications had been given that it was an imminent likelihood that conditions would arise whereby a nurse should be available to her at all times, skilled nursing services were neither received nor required.

Based on the facts as presented in the instant case it is accordingly *held* that the care received by R at the N Nursing Home from January 2, 1977, through March 7, 1977, was custodial and therefore excluded from coverage by section 1862(a)(9) of the Social Security Act.

(X—Refer to SSR 70–37)

SECTIONS 1814(a)(2)(C) and 1862(a)(9)—HOSPITAL INSURANCE BENEFITS—CUSTODIAL CARE EXCLUSION—SERVICE FOLLOWING STABILIZATION OF PATIENT'S CONDITION

HCFAR 79–49c*

Preuc v. Secretary of Health, Education, and Welfare, U.S.D.C., Kansas, Civil Decision No. KC–3164 (12/3/70) (CCH, Medicare and Medicaid Guide, Fed. Para. 26,230).

A hospital insurance beneficiary was admitted to an extended care facility* on January 20, following a qualifying hospital stay.

The admitting diagnosis was acute and chronic pulmonary obstructive disease, dehydration, malnutrition, cerebal arteriosclerosis, and Parkinson's syndrome. Intravenous injection of glucose were administered weekly. Intramuscular injections of Vitamin B-12 were administered 3 times weekly until April 29 when they were reduced to twice a week. The nurses' notes described the services furnished the beneficiary as "routine care, routine personal care, up on chair, up and about room, watching television, ate well, appetite fair, slept long intervals, appears in good mood, no complaints, no care ordered." The court *held* that there was substantial evidence in the record to sustain the Secretary of Health, Education, and Welfare's decision that the claimant's condition in the extended care facility had stabilized and was controlled with proper medication and that payment for the services he received after February 18 must be denied since they did not constitute skilled nursing care on a continuing basis* as required by section 1814(a)(2)(C) of the Social Security Act but were instead custodial in nature and therefore excluded from coverage by section 1862(a)(9) of the Act.

Stanley, District Judge: This is a petition for review of the decision of the Secretary of Health, Education, and Welfare, denying post-hospital extended care benefits provided under the Social Security Act, 42 U.S.C.A. §1395d(a)(2). Jurisdiction to review the action of the Secretary is vested in this court by virtue of 42 U.S.C.A. §1395ff.(b). The matter is now before the court upon cross motions for summary judgment.

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* *Case decisions decided in the Federal courts upon appeal from the decision of the Secretary, HEW, are identified throughout the publication by a suffix "c" after the ruling number.*

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* P.L. 92–603, constituting the Social Security Amendments of 1972, provides that wherever the term "extended care facility" appeared in title XVIII of the Social Security Act, the term "skilled nursing facility" should be substituted therefor, beginning October 30, 1972, the date of enactment.

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* Effective January 1, 1973, 1814(a)(2)(C) was amended to the following "in the case of posthospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or required the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving inpatient hospital services."

The basic facts are as follows: Frank L. Preuc, now deceased, entered Providence Hospital on December 28, 1968 with an admitting diagnosis of lower respiratory infection. He was treated at Providence until January 20, 1969, when he was released by Providence and taken immediately by ambulance to Wesleyan Convalescent Center (hereinafter Wesleyan). His admitting diagnosis at the latter institution was acute and chronic pulmonary obstructive disease, dehydration, malnutrition, cerebral arteriosclerosis, and Parkinson's syndrome. Mr. Preuc remained in Wesleyan beyond April 29, 1969, which is the end of the critical period, since the benefits plaintiff seeks to recover are limited to 100 days of care. Preuc was given weekly intravenous injections of glucose at Wesleyan from the time of his transfer until March 18, 1969, which was the date the last such injection was administered. He also was given intramuscular injections of Vitamin B–12 three times weekly until April 29, 1969, when these shots were reduced to twice weekly.

The testimony of only one witness was taken in connection with this proceeding, that of Mrs. Brady, a registered nurse and Medicare Coordinator for Wesleyan. The transcript of that testimony has been proffered in connection with the present motions. Mrs. Brady did not participate in the care which Preuc received, and testified solely from the hospital records. In summarizing the most important of her testimony, she stated that intravenous injections were usually administered by a registered nurse or by a physician and that it would be difficult to give them on an outpatient basis, but that it could probably be done. She also testified that Wesleyan maintained separate sections in a single building for hospital, extended care, and custodial patrons. Mr. Preuc was not transferred out of the extended care section within the critical period and there is some indication in the record that he was transferred to a different area of the Wesleyan Center on the same day that the period of coverage under the Social Security Act, for extended care benefits, ended.

The sole issue in this case is whether there is substantial evidence in the record to support the decision of the Appeals Council of the Social Security Administration. That body determined that the claimant was entitled to extended care benefits from January 20, 1969 to February 18, 1969. It was also held, however, that the services which the claimant received after February 18, 1969 were custodial in nature and therefore excluded from coverage by §1862(a)(9) of the Social Security Act, now 42 U.S.C.A. §1395y(9).

As both parties recognize, 42 U.S.C.A. §405(g) requires this court to give conclusive effect to the findings of the Secretary as to any fact, if supported by substantial evidence. This limitation on the scope of judicial review extends not only to the factual findings of the Secretary, but also to inferences and conclusions drawn from the evidence. *Johnson v. Gardner*, 368 F. 2d 909 (10th Cir. 1966); *Gainey v. Flemming*, 279 F. 2d 56 (10th Cir. 1960); *Vineyard v. Gardner*, 376 F. 2d 1012 (8th Cir. 1967). Thus, if there is substantial evidence in the record to support the factual findings, inferences, and conclusions of the Secretary, his determination is conclusive, even though the court might have reached an opposite conclusion if it had been free to consider the matter *de novo*. *Henry v. Gardner*, 381 F. 2d 191 (6th Cir.), *cert. denied*, 389 U.S. 993 (1967). *rehearing denied*, 389

U.S. 1060 (1968). As to what constitutes substantial evidence, this phrase has been defined as enough evidence "to justify a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury." *Mims v. Celebrezze*, 217 F. Supp. 581, 582–3 (D. Colo. 1963). See also *Dowling v. Ribicoff*, 200 F. Supp. 543 (S.C. N.Y. 1961); *Woolridge v. Celebrezze*, 214 F. Supp. 686 (S.D. W. Va. 1963).

The decision of the Appeals Council was based primarily upon the medical records of Providence Hospital and Wesleyan, and the variance between the discharge record at Providence, which reported the patient's condition as improved, and the admitting diagnosis at Wesleyan. [a] The Appeals Council also made the following comment in the course of its opinion:

> Considerable insight into the nature and extent of the care given the claimant at Wesleyan can be educed from the nurses' daily notes, which describe the services rendered as "routine care, routine personal care, up on chair, up and about room, watching television, ate well, appetite fair, slept long intervals, appears in good mood, no complaints, no care ordered."

The Appeals Council found that the claimant's overall physical condition while at Wesleyan was stabilized and controlled with appropriate medication after the first 30 days, and that he neither required nor received continuous close observation by skilled nurses. Specific findings were also made as to the intravenous and intramuscular injections which the claimant received at Wesleyan, the Appeals Council indicating that these injections did not constitute skilled nursing care "on a continuing basis" as required by the Act, and that, in any event, they could have been provided outside an institutional setting. I have not attempted to document all of the evidence upon which the findings of the Secretary are based, as to do so would unnecessarily lengthen this memorandum. Suffice it to say that I believe and hold that there is substantial evidence in the record, as that phrase is defined in cases cited earlier in this memorandum, to support the findings of fact, inferences, and conclusions of the Appeals Council.

IT IS ORDERED that the plaintiff's motion for summary judgment be denied.

IT IS FURTHER ORDERED that the defendant's motion for summary judgment be granted.

(X—Refer to SSR 71–48c)

SECTION 1814—PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED—EMERGENCY SERVICES REQUIREMENT FOR NONPARTICIPATING PROVIDER

42 CFR 405.152 HCFAR 79–50

(This is a reprint of HCFAR 78–4(p. 12) which updates certain references not included in the original printing)

Where an individual entitled to hospital insurance benefits under title XVIII of the Social Security Act was furnished inpatient hospital services by a hospital not qualified as a participating provider under title XVIII, *held*, hospital not entitled to have payment made to it when it was not established that the hospital services constituted "emergency services" within the meaning of section 1814 of the Act and regulations thereunder.

On March 6, 1978, A, who was entitled to hospital insurance benefits under title XVIII of the Social Security Act, was admitted to X Hospital because of an acute upper respiratory infection. A signed a request that the hospital be paid on his behalf for the services furnished him. On March 7, 1978, A's attending physician signed a mimeographed form containing the statement that "the patient required emergency services to prevent death or serious impairment of health of this individual and which because of the threat to the life or health of the individual, necessitated the use of this the most accessible hospital available equipped to furnish such services." On March 13, 1978, A was discharged from the X Hospital, having received drug therapy which improved his condition. On that date, the X Hospital, which is not a participating provider under title XVIII, submitted a statement requesting payment from the Health Care Financing Administration for emergency inpatient hospital services furnished to A.

Section 1814 of the Act provides, in pertinent part, that payment for hospital services furnished an individual may be made only to providers of services who, by agreement with the Secretary, have qualified to participate in title XVIII of the Social Security Act. However, payment will also be made to any hospital for inpatient hospital services furnished by it to an individual entitled to hospital insurance benefits, even though such hospital is not a participating provider under title XVIII if, in addition to other requirements which are not at issue herein, such services were emergency services.

The issue to be resolved is whether the inpatient hospital services furnished A by the X Hospital constitute "emergency services" within the meaning of section 1814 of the Act, and regulations of the Administration promulgated thereunder.

Emergency services are those inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services.

A determination as to whether services furnished are "emergency services" will, ordinarily, be based upon medical evidence on the apparent condition of the patient at the time of his arrival at the hospital, including a physician's conclusions as to his condition following examination of the patient. No payment under the hospital insurance program can be made to a nonparticipating hospital for services furnished after the emergency has ended. Also, hospital services are no longer considered "emergency services" when it is no longer necessary, from a medical standpoint, to care for the patient in a nonparticipating hospital.

The facts show that A had been suffering from a respiratory impairment over an extended period of time. He was examined by his attending physician on March 5, 1978, because of respiratory difficulties, and was advised to enter the hospital. However, A told the doctor he would wait until the next day to see if his condition improved and, if it did not, he would take the doctor's advice. When his condition did not improve, A entered X Hospital the next day, March 6, 1978. Hospital records show that he was admitted for the relief of chest pains, sore throat, coughing and hoarseness. A routine chest x-ray examination made on March 7 was interpreted as revealing the existence of fibrosis and emphysema and an otherwise negative chest. Treatment by means of drug therapy resulted in improvement and he was discharged a week later.

A has not contended—nor does the evidence of record establish—that his admission to the X hospital was in the nature of an emergency, as defined above, that a hospital participating under title XVIII was not available, or that the X Hospital was the most accessible hospital available equipped to furnish the hospital services which he required. He waited one day before acting on the doctor's advice to enter a hospital. In addition, the record reveals that there were two hospitals participating under title XVIII which were available to A, but he preferred to be hospitalized at the X Hospital, since his attending physician treated his patients there, and A's wife and stepson were also patients there. A's selection of the X Hospital was his free choice, made voluntarily for personal reasons entirely unassociated with any existing emergency. A's right to obtain hospitalization at any hospital he chooses is unquestioned. However, in order for payment to be made on his behalf by reason of the fact that he has been furnished hospital services, it must be established that the services were furnished either by a hospital participating under title XVIII, or, if by a nonparticipating hospital, that the services were "emergency services" as defined above. It is well-established by numerous court decisions that one who files a claim with an administrative agency has the burden of proving that the required conditions of eligibility have been met. See *Norment v. Hobby* 124 F. Supp. 489. The claimant here has not met that burden.

It is accordingly *held* that the inpatient hospital services furnished A by the X Hospital do not constitute "emergency services" within the meaning of section 1814 of the Social Security Act and regulations thereunder, and payment may not be made on A's behalf to the X Hospital, a nonparticipating provider under title XVIII of the Act.

(X—Refer to SSR 69–22)

SECTION 1814(d)—HOSPITAL INSURANCE—NONPARTICIPATING HOSPITAL—EMERGENCY SERVICES

42 CFR 405.191 HCFAR 79–51

(This is a reprint of HCFAR 78–9(p. 27) which updates certain references not included in the original printing)

Where a hospital insurance beneficiary with a chronic arthritic condition is admitted to a hospital eligible for payment under title XVIII of the Social Security Act only for "emergency services," to secure surgical relief for intense pain in her hip, and where there was no medical evidence of a sudden or significant change in her condition, *held*, the hospital is not entitled to payment for the inpatient services it furnished, since such services did not constitute "emergency services" within the meaning of section 1814 of the Act.

R, who is entitled to hospital insurance benefits under title XVIII of the Social Security Act, was admitted to the N Hospital August 22, 1978, because of intense pain in the hip. R had an advanced rheumatoid arthritic condition which had not responded to other treatment, and she underwent hip surgery 2 days after admission. She was discharged on November 1, 1978, based on the physician's statement that the emergency had ceased. A claim for payment pursuant to section 1814(d) of the Act, for the inpatient hospital services furnished R has been made by the N Hospital, a nonparticipating hospital which could claim payment under the program for emergency services only.

Section 1814 of the Social Security Act, as here pertinent, provides:

(d) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements . . . with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services . . . .

The issue to be resolved in this case is whether the inpatient hospital services provided R by the N Hospital constitute emergency services within the meaning of section 1814 of the Social Security Act.

"Emergency services" are defined as those inpatient hospital services which are necessary to prevent death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available, and equipped to furnish such services. A determination as to whether services furnished are "emergency services" will ordinarily, be based upon the medical evidence on apparent condition of the patient at the time of his arrival at the hospital including a physician's conclusions as to his condition following examination of the patient. No payment under the hospital insurance program can be made to a nonparticipating hospital for services furnished after the emergency has ended. Also, hospital services are no longer considered "emergency services" when it is no longer necessary, from a medical standpoint to care for the patient in a nonparticipating hospital.

Based on the facts in this case it appears that R had recurring pain in her hip which had defied medical treatment and the orthopedist believed that surgical therapy was indicated. R's arthritis was becoming progressively worse but there was no indication of any sudden or significant change in her condition which necessitated immediate hospitalization on or about August 22, 1978. R's husband stated that there was a participating hospital which he contacted prior to her admission but it did not have a room available.

The fact that R's husband may have made a preliminary inquiry at a participating hospital and become discouraged when told that his wife could not be admitted in the immediate future does not establish that R could not have been accommodated in a participating hospital. Generally, if a physician recommends hospitalization and surgery, he arranges for the patient's admission to a hospital. There is no evidence that the attending physician attempted to have R admitted to any participating hospital in the immediate area or that, once the surgery was performed and the pain relieved, there was any attempt to transfer R to a participating hospital.

It has not been established from the above facts that R's admission to the N Hospital was in the nature of an emergency, as defined above, that a hospital participating under title XVIII would not have been available to accommodate her had the physician made the necessary arrangements therefor, or that the N Hospital was the most accessible hospital available equipped to furnish the hospital services required by R.

Therefore it is *held,* R was not furnished "emergency services" within the meaning of section 1814 of the Social Security Act by the N Hospital and accordingly payment cannot be made to the hospital on R's behalf.

(X—Refer to SSR 70–26)

SECTION 1814(d)—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—ACUTE MEDICAL CONDITION OCCURRING IN NONPARTICIPATING HOSPITAL SUBSEQUENT TO CESSATION OF ORIGINAL EMERGENCY

42 CFR 405.152 and 405.191 HCFAR 79–52

(This is a reprint of HCFAR 78–10 (p. 28) which updates certain references not included in the original printing)

When a hosptial insurance beneficiary suffering from a heart attack is admitted to a nonparticipating hospital on an emergency basis and subsequent to the cessation of the acute medical condition for which she was originally hospitalized, she submits to an elective surgical procedure which gives rise to a second acute medical condition, *held,* inpatient hospital services furnished by the nonparticipating hospital for the treatment of the second acute medical condition occurring after the cessation of the initial medical emergency for which she was originally admitted, are not covered emergency inpatient hospital services within the meaning of section 1814(d) of the Social Security Act.

M, a hospital insurance beneficiary, was admitted to a hospital on an emergency basis, suffering from congestive heart failure, pneumonia, and an acute myocardial infarction. The hospital, although not participating as a provider of services under title XVIII of the Social Security Act, was eligible to receive payment for emergency services pursuant to section 1814 of the Act. After an initial period of treatment, M recovered from the acute medical condition which was the basis for the orginal emergency admission to the extent that an elective surgical procedure was performed. Following the surgery, M suffered a second myocardial infarction which was severe enough to be considered acute. Payment was made on M's behalf for the care and services provided by the nonparticipating hospital for the original emergency admission pursuant to section 1814(d) of the Social Security Act. However payment has been denied for the period of hospitalization for the subsequent acute medical condition which occurred some time after cessation of the original medical emergency. M has protested this decision.

Thus, the issue to be resolved in the instant case is whether or not an acute medical condition, which occurred while M was an inpatient in a nonparticipating hospital, following cessation of the emergency condition for which she was originally admitted, comes within the scope of the statutory term "emergency" in section 1814(d) of the Social Security Act.

Section 1814(d) of the Act, which contains the controlling provisions pertaining to coverage of emergency hospital services, provides, as pertinent here, that:

> (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements . . . with it, to an individual entitled to hospital insurance benefits . . . even though such hospital does not have an agreement in effect under this title if (A) such services were *emergency* services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient *emergency* services . . . furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a). (Emphasis supplied.)

Although the language contained in section 1814(d), supra, does not specifically resolve the question posed in the instant case, that is, whether a crisis arising when the patient is *in the hospital* constitutes the emergency, the Senate Finance Committee report (Sen. Rept. No. 404, 89th Congress, 1st Sess. 1965, page 30) provides further guidance thereon, as follows:

> The committee recognizes that there will be emergency situations where an individual who is eligible for hospital insurance benefits will *go or be taken to a hospital* that does not participate in the program. For example, an accident victim might *have to be taken immediately to the nearest* hospital, either for outpatient diagnosis and treatment or for admission as an inpatient. The committee's bill would permit the payment of benefits for emergency hospital diagnostic services or inpatient care in such cases until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution.[1] (Emphasis supplied.)

[1] See also in this regard H. Rept. No. 213, 89th Cong., 1st Sess. (1965) p. 26.

Although the committee language concerning the transporting of an injured beneficiary to the nearest hospital is illustrative, it must be considered when determining the scope of the definition of the emergency hospital services which are covered under section 1814(d) of the Act. This language also has a bearing on the definition of the term "emergency" because of the parallel reference to emergency hospital services furnished outside the United States which occurs in section 1814(f)(2), as follows:

> Payments may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—
>
> (A) such individual was physically present—
>
> (i) in a place within the United States; or (ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;
>
> at the time the emergency which necessitated such inpatient hospital services occurred; and
>
> (B) such hospital was *closer to, or substantially more accessible from, such place than the nearest hospital within the United States* which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury. (Emphasis supplied.)

On the basis of the committee reports which accompanied the original Medicare legislation and the 1972 Amendments to that legislation, there appears to have been a pervasive congressional desire that for emergency hospital services the nearest appropriate hospital facilities be used. This gives rise to the implication that the term "emergency" was intended to refer only to acute medical conditions which occur outside of a hospital and necessitate transportation of the patient to a hospital. This can be seen further in the regulations promulgated by the Secretary of Health, Education, and Welfare for the purpose of facilitating the administration of title XVIII of the Social Security Act. For example, section 405.191 of the Health Care Financing Administration's Regulations (42 CFR 405.191) interprets an emergency (for purposes of section 1814(d) of the Act) as a situation occurring outside of a nonparticipating hospital which necessitates transport to such hospital for purposes of admission therein. It states, in pertinent part, that:

> (a) General—Payment to a nonparticipating hospital for emergency services (as defined in §405.152(b)) can be made only for the period during which the emergency exists.
>
> (b) Objective—The objective of paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services only to periods during which the patient's state of injury or disease is such that a *health or life-endangering emergency existed and continued to exist,* requiring immediate care which could only be provided in a hospital.
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> * * * * *
>
> (3) *Existence of medical necessity for emergency services is based on the physician's assessment of the patient prior to admission to the hospital. Therefore, conditions developing after a nonemergent admission are not considered emergency services for purposes of this subparagraph.* (Emphasis supplied.)

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Thus, the above cited materials clearly contemplate an emergency as being a situation where a person, who is outside of a hospital, requires hospitalization but does not have the ability to choose the particular institution to which he is to be admitted because the medical exigencies relating to his condition require that he be hospitalized immediately. Therefore, an emergency so conceived would not initially arise as the result of those acute or aggravated medical situations or conditions which occur to individuals, either originally or as the result of a previous disease or injury, while such individuals are inpatients in a nonparticipating hospital.

Such a limited concept of emergency is required not only by a technical construction of the Act and the attendant legislative history, but by the general overall philosophy of the Medicare statute. For example, nonparticipating hospitals which furnish these emergency services are not required to meet all of the section 1861(e) statutory program requirements in order for the emergency services they furnish to be covered services. Such hospitals need only comply with the statutory nursing and State licensing requirements of paragraphs (5) and (7) of section 1861(e).

The emergency inpatient hospital service concept is an exception to the general rule that inpatient hospital services are covered only when furnished in hospitals which fully comply with all of the statutory requirements. This limited exception to program participatory requirements applies only to actual emergency situations where the beneficiary (or his physician) because of supervening medical necessity may not be able to elect to utilize a participating hospital which meets the conditions of high level care required by the Act. This limited exception thus ensures the Medicare beneficiaries will not be disadvantaged by being denied program coverage for essential hospital services furnished in nonparticipating hospitals because of an unexpected acute medical condition suffered by the beneficiary.

The construction of the term "emergency" urged by the claimant would expand the concept of an emergency to include any acute medical conditions occurring to Medicare beneficiaries irrespective of the place of their occurrence.

If the definition of emergency inpatient hospital services were extended by interpretation to include services furnished by nonparticipating hospitals to individuals who entered on a nonemergency basis, or the acute medical conditions arising while there, such nonparticipating hospitals could receive program payments.[3] Under such circumstances the nonparticipating hospitals might lose their incentive to meet the conditions for participation in the health insurance program.[4]

Accordingly, it is *held* that the acute medical condition experienced by M while confined in a nonparticipating hospital on a nonemergency basis after the cessation of the acute medical condition for which she was originally hospitalized is not an emergency within the contemplation of section

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[3] If they have elected to claim payment for all emergency inpatient services furnished during that calendar year. Section 1814(d)(1) of the Act.

[4] The total dollar amounts of these potential payments, both to hospital and to beneficiaries, cannot be presumed to be insignificant in view of the disproportionately high amount of medical services required by persons over 65.

1814(d) of the Act. Thus inpatient hospital services furnished in response to a subsequent acute medical condition are not covered as emergency services under title XVIII of the Social Security Act.

(X—Refer to SSR 70–48)

SECTION 1814.—HOSPITAL INSURANCE BENEFITS—ADMISSION TO NONPARTICIPATING HOSPITAL—RADIATION TREATMENT FOR CONDITION NOT CONSIDERED EMERGENCY SERVICES

42 CFR 405.152, 405.191, and 405.192 HCFAR 79–53

Where a hospital insurance beneficiary is admitted to a nonparticipating hospital eligible under title XVIII of the Social Security Act for payment only for "emergency services," and the equipment in a participating hospital in the immediate area is alleged to be inferior for administering cobalt radiation to treat her condition, symptoms of which appeared 2 weeks prior to her admission, *held* payment of hospital insurance benefits is precluded since the services furnished were not "emergency services" within the meaning of section 1814 of the Act. Furthermore, where no emergency condition existed requiring an emergency admission to a nonparticipating hospital, the accessibility of a participating hospital available and equipped to furnish the necessary services is not a factor in determining whether hospital insurance benefits may be paid.

F, a hospital insurance beneficiary was admitted to the S Hospital on December 30, 1977, after suffering for 2 weeks from pain in the sacroiliac region due to metastatic carcinoma for which treatment with cobalt radiation was prescribed. F remained in the hospital until discharged on January 15, 1978. The S Hospital does not participate in the Medicare program except as a provider of emergency services. A request for payment has been filed by the hospital for the inpatient hospital services furnished F pursuant to section 1814 of the Social Security Act.

Section 1814 of the Act provides, as pertinent here, that payment for hospital services furnished a hospital insurance beneficiary may be made to providers of services who, by agreement with the Secretary of Health, Education, and Welfare, have qualified to participate in title XVIII of the Social Security Act. Payment also may be made to a nonparticipating hospital for inpatient services furnished to such individual if, in addition to other requirements which are not here at issue, such services were "emergency services."

The issue to be resolved here is whether the inpatient hospital services furnished F by the S Hospital constitute "emergency services" within the meaning of section 1814 of the Social Security Act, and the regulations promulgated thereunder.

For purposes of the hospital insurance benefits program, "emergency services" are those inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to his life or health, necessitate the use of the most accessible hospital available which is equipped to furnish such services.

Section 405.152(b) of Regulations of the Health Care Financing Administration (42 CFR 405.152(b)).

Section 405.191 of the Health Care Financing Administration Regulations (42 CFR 405.191), as pertinent here, provides:

> (a) General—Payment * * * for emergency services * * * can be made only for the period during which the emergency exists.
>
> (b) Objective—The objective of paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services only to periods during which the patient's state of injury or disease is such that a health or life-endangering emergency existed and continued to exist, requiring immediate care which could only be provided in a hospital.
>
> (1) The finding that an emergency existed and/or has ceased will ordinarily be supported by medical evidence including the attending physician's supporting statement * * * and, when appropriate, information furnished by the hospital. However, a statement by the physician or hospital that an emergency existed, in the absence of sufficient medical information to establish the actual emergency, will not constitute sufficient evidence of the existence of an emergency.
>
> (2) An emergency no longer exists when it becomes safe from a medical standpoint to move the individual to a participating hospital or other institution, or to discharge him.
>
> (3) Existence of medical necessity for emergency services is based on the physician's assessment of the patient prior to admission to the hospital. Therefore, conditions developing after a nonemergent admission are not considered emergency services for purposes of this subparagraph.
>
> * * * * *
>
> (5) Lack of transportation to a participating hospital does not constitute a reason for emergency hospital admission, unless there is also an immediate threat to the life and health of the patient.

Section 405.192 of the Health Care Financing Administration Regulations (42 CFR 405.192) provides, in part:

> (a) General—Services to be emergency services * * * must be furnished by the most accessible hospital available and equipped to furnish such services.
>
> (b) Objectives—The objective of the requirement in paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services provided by nonparticipating hospitals to situations where transport of the patient to a participating hospital would have been medically inadvisable, e.g., the participating hospital would have taken longer to reach and the patient's condition necessitated immediate admission for hospital services; and for so long as that condition precluded the patient's discharge or removal to a participating hospital.
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> * * * * *

With regard to F's condition, her physician stated on March 27, 1978: "The (S) Hospital is the only medical facility in the community with the necessary equipment to provide cobalt radiation to the affected bones. . . ." He continued that, "(t)he conventional radiation equipment at the (T)

Hospital (a participating hospital in the community) is definitely inferior to that at the (S) Hospital. If the equipment at the (T) Hospital had been used, (F) would have had poorer quality treatment. . . ."

The hospital record indicates that at the time of F's admission to the S Hospital she had a history of pain in the sacroiliac area for 2 weeks prior to admission. In addition to extensive bone involvement which had been previously documeted she was, "(a)dmitted on this occasion for evaluation. RE (recommendation) further X-ray therapy."

The physician's progress notes dated January 1, 1978, indicate no new medical evidence and further show that cobalt treatment was to have begun on January 3, 1978.

While there is no question that F's condition was serious and required medical attention, the facts reveal no acute medical condition which would require an emergency admission to any hospital. On the contrary, the evidence shows, based on the specific statements of F's attending physician, that this was an elective admission for treatment with cobalt therapy by the radiologist in the hospital.

For payment to be made for "emergency services" within the meaning of section 1814 of the Social Security Act, the evidence must establish that an emergency condition existed requiring emergency admission to a hospital. While it may be true that the S Hospital was the only hospital in the immediate area properly equipped to treat F's condition, where there is no emergency condition requiring emergency admission to a nonparticipating hospital, accessibility of a participating hospital available and equipped to provide the needed services is not a factor for consideration in determining whether hospital insurance benefits are payable (see sections 405.191 and 405.192 of the Health Care Financing Administration Regulations *supra*).

Accordingly, it is *held* that the inpatient hospital services furnished F by the S Hospital do not constitute "emergency services" within the meaning of section 1814 of the Social Security Act and the regulations thereunder, and therefore payment may not be made on F's behalf to the S Hospital, a nonpartcipating provider under title XVIII of the Act.

(X—Refer to SSR 71–49)

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42 CFR 405.152 HCFAR 79–54

(This is a reprint of HCFAR 78–13 (p. 38) which updates certain references not included in the original printing)

Where a nonparticipating hospital, qualified to furnish emergency services, furnished services to a beneficiary upon a physician's supporting statement that a medical emergency existed, but the evidence failed to establish that the condition of the beneficiary at the time of admission was such as to require emergency services, as that term is defined in section 1814 of the Act, *held*, the services did not constitute emergency services within the meaning of section 1814 and accordingly, no payment may be made to the hospital for the services furnished.

R, a 90-year old woman entitled to hospital insurance benefits under the Social Security Act, awoke immobile on March 27, 1976, with acute back and kidney pains. Her daughter in a nearby town and her physician were notified and arrangements were made to transport R by auto to the family physician 12 miles away. However, before departure the daughter performed several personal errands, bathed and dressed R, and assembled her personal belongings. Upon arrival, R waited her turn in the doctor's office; then, after an examination and completion of laboratory tests, the physician immediately ordered R to the M Hospital, a local nonparticipating hospital, as an emergency patient. She was admitted at 4:15 P.M., as a Medicare emergency upon a supporting statement by the physician as to R's severe chest and back pains. However, all findings on her physical examination by the admitting physician at the hospital, some 7½ hours after initial complaint, were negative, normal, unremarkable, except for her carcinoma and chronic pyclonephritis, conditions for which she had been treated some time earlier at the X Clinic. R was discharged from the M Hospital on May 12, 1976. A bladder tumor was discovered some three weeks later; however, R did not enter X Clinic for treatment until October 1976. She died November 3, 1976. The M Hospital applied for payment for emergency hospital services, furnished to R, pursuant to section 1814(d) of the Act.

Section 1814(d) of the Act provides in pertinent part:

(d)(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements * * * with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and * * *

Further provision for reimbursement for services provided by a nonparticipating hospital furnishing emergency services, is made by section

405.152 of the Health Care Financing Adminstration Regulations (42 CFR 405.152), which provides, in part, as follows:

> (a) Payment * * * may be made to a hospital even though the hospital is not a participating provider (i.e., it has not entered into an agreement with the Secretary, pursuant to section 1866 of the Act * * *) if:
> (1) The hospital meets the requirements of section 1861(e)(5) and (7) of the Act * * *, and; * * *
> (2) The services furnished are emergency services (see paragraph (b) of this section) furnished an individual who meets the requiremnts of §405.102;
>
> * * * * *
>
> (b) For purposees of the hospital insurance benefit program, "emergency services" are those inpatient hospital services * * * which are necessary to prevent the death or serious impairment of the health of the individual, necessitate the use of the most accessible hospital * * * available and equipped to furnish such services. * * *

The issue presented is whether the services rendered to R by the M Hospital were emergency services for which payment would be required under section 1814(d) of the Act.

On the basis of the above presented facts, R's hospital admission failed to reflect an emergency by any standard. The statement by an attending physician, unless supported by medical or clinical evidence, will not support a contention that a medical emergency existed. In this case, no ambulance was immediately summoned to the house. R was taken by auto to the doctor, awaited her turn in his office, and was admitted to the hospital some 7½ hours after the onset of her pains. The hospital records contained no indication of emergency or nearness of death, and in fact showed that R's condition continued to improve after the second day. R's carcinoma was known, proven, diagnosed and had been treated at the X Clinic and by the family physician. Her pycloncphritis condition was chronic; the discovery of a bladder tumor some weeks after the hosptial admission appears not directly related to any medical emergency.

The M Hospital admission records indicated only mild distress. Since R had previously been treated in the X Clinic for carcinoma, we may assume that she would have been referred there again for any acute complications of the disease. The fact that a person becomes progressively debilitated because of a neoplastic disease does not establish the existence of an emergency for hospital reimbursement purposes.

Accordingly, it is *held* that the inpatient hospital services furnished R during the period March 27, 1976, through May 12, 1976, do not constitute "emergency services" within the meaning of section 1814 of the Act; therefore, payment cannot be made on R's behalf to the nonparticipating M Hospital.

SECTION 1814(d)(1)(A)—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—EMERGENCY OCCURRING AFTER A NON-EMERGENCY ADMISSION TO HOSPITAL

HCFAR 79–55c

Cary v. Finch, 316 F. Supp. 1263 (E.D. La., 7/15/70)

Where a hospital insurance beneficiary required emergency care for a broken hip suffered the day after she was admitted to a nonparticipiating hospital for X-rays and diagnostic tests to determine the cause of pain in her hip, *held*, the Secretary of Health, Education, and Welfare was justified in finding that payment to the hospital may not be made on the individual's behalf, since no emergency existed at the time of her admission to the hospital, as required by section 1814 of the Social Security Act which permits payment to certain nonparticipating hospitals for emergency services, and regulations thereunder.

Rubin, *District Judge:* At the heart of this case is the question of the validity of a regulation adopted by the Secretary of Health, Education and Welfare.

Sections 1801 through 1901 of The Social Security Act contain the "Medicare" provisions. 42 U.S.C. § 1395, *et seq.* Payment for services furnished an individual may be made only to those providers of services that have established their eligibility. 42 U.S.C. § 1395f.[1]

But "payments shall also be made to any hospital for in-patient services furnished * * * to an individual entitled to hospital insurance benefits * * * even though such hospital does not have an agreement in effect under this subchapter if (A) such services were emergency services * * * 42 U.S.C. § 1395f(d)(1).

Pursuant to his statutory authority, 42 U.S.C. § 1395hh,[2] the Secretary of HEW has adopted regulations defining emergency services.[3] One part of these regulations reads:

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[1] Section 1395cc sets out the requirements which hospitals must meet in order to be providers of services" under § 1395f. The basic requirement of § 1395cc is that the hospital have an agreement in effect with the Secretary of Health, Education and Welfare.

[2] The Secretary [of HEW] shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter.

[3] Section 405.152(b), published in 42 CFR § 405 *et seq.*, defines emergency services as follows:

> For purposes of the hospital insurance benefits program, "emergency services" are those inpatient services * * * which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital (see Section 405.192) available and equipped to furnish such services * * *

Section 405.192 establishes the rules for determining whether or not services are furnished by the most accessible hospital available and equipped to furnish such services. In addition, this section provides further intepretation by the Secretary of the meaning of the term "emergency services."

> Existence of Medical necessity for emergency services is based on the physicians assessment of the patient prior to admission to the hospital. *Therefore, conditions developing after a non-emergent admission are not considered emergency services for purposes of this subparagraph. Section 405.191(b)(3).*

There is no dispute about any of the material facts. During the month of May 1968, Mrs. Amelia B. Fourticq, who was then 81 years old, was preparing to take a trip from New Orleans to San Antonio when she felt pains in her right leg. She consulted and was treated by Dr. Solomon Winokur, who referred her to Dr. Robin Hardy for X-rays. Both Dr. Winokur and Dr. Hardy diagnosed the pain in her right leg and hip area as arthritis and she was treated by Dr. Winokur almost daily for two weeks.

Since her pain continued, Dr. Lloyd C. Eyrich was consulted on June 4, 1968. He examined Mrs. Fourticq at home and recommended that she be sent to a hospital for X-rays, to determine what treatment should be administered. An application for admittance to Southern Baptist Hospital was made immediately, but no bed was available for Mrs. Fourticq for nine days thereafter. She was finally admitted to Southern Baptist Hospital on June 13, 1968, for the purpose of taking X-rays of her leg and performing other minor diagnostic tests. Southern Baptist was not then participating in the Medicare program and Mrs. Fourticq knew this when she sought to be admitted.

Although taken to the hospital in an ambulance, Mrs. Fourticq was feeling fine. X-rays were taken the day she arrived at the hospital, but they failed to show anything wrong with her hip. The next day Dr. James Lenoir, an orthopedist, was consulted. He recommended that further X-rays be taken in the area of the knee, instead of solely in the hip. Because of the severe pain which had developed after the initial X-rays, Mrs. Fourticq could not be moved, and X-ray equipment was brought in to her room to examine the lower portion of her leg. At that time, it was discovered that the bone had been practically eaten away by cancer and, while additional X-ray pictures were being taken, the bone broke.

An immediate operation was necessary to repair the fracture. Consideration was given to transferring Mrs. Fourticq to a hospital participating in the Medicare program but the doctors felt she could not be moved. The operation was performed on June 14, 1968. On July 17, 1968, at 11:15 P.M., Mrs. Fourticq died, without ever having left Southern Baptist Hospital.

In this action, Mrs. Fourticq's son-in-law seeks to recover benefits for expenses incurred by the hospitalization of Mrs. Fourticq at the Southern Baptist Hospital from June 14, 1968 to July 18, 1968. The hearing examiner recommended that the claim be allowed, but the HEW Appeals Council reversed his decision on the ground that Mrs. Fourticq's hospitalization was not for "emergency services."

Both parties now move for summary judgment. Since the statute stipulates, "The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive," 42 U.S.C. § 405(g),[4] this court's

[4] 42 U.S.C. § 1395ii makes this section applicable to administrative decisions under the Medicare Act, through reference to 42 U.S.C. § 405(h).

review is restricted to the question whether the Appeals Council's decision is supported by substantial evidence. *Knox* v. *Finch,* 5 Cir. 1970, 427 F. 2d 919; *Burdett* v. *Finch,* 5 Cir. 1970, 425 F. 2d 687; *Martin* v. *Finch,* 5 Cir. 1969, 415 F. 2d 1973; *Labee* v. *Cohen,* 5 Cir. 1969, 408 F. 2d 998; *Celebrezze* v. *O'Brien,* 5 Cir. 1963, 323 F. 2d 989; *McGaughy* v. *Gardner,* E.D. La. 1967, 264 F. Supp. 820.

Based on an examination of the record, which includes a transcript of the proceedings before the hearing examiner, it is my conclusion that the Appeals Council did have substantial evidence on which to base its decision in this case. Actually, there is no dispute as to the *facts* surrounding Mrs. Fourticq's condition when she entered Southern Baptist Hospital; the controversy centers on whether the Appeals Council used an appropriate standard, under the Medicare statute, in denying plaintiff's claim on these facts.

The hearing examiner decided that "the written and oral evidence indicates that an emergency situation existed at the time [Mrs. Fourticq] was admitted and continued until she was discharged." But the hearing examiner applied the wrong criterion: he looked to Mrs. Fourticq's condition in fact, not to her physician's assessment at the time.

There is no doubt that, when Mrs. Fourticq was admitted to Southern Baptist Hospital, her physician viewed her condition as non emergent. At that time the physician responsible for treating her considered that her health permitted her, without undue danger, to wait nine days for admission for diagnostic tests. She was not thought to require emergency care. The claimant in effect concedes that, at the time of admission, no emergency existed, because he does not claim benefits for the day of June 13, when Mrs. Fourticq was admitted to the hospital. Rather, the claim for emergency care payments is made only for the period beginning June 14, when her hip broke.

Claimant stresses that the cancer that led to her death did not "develop" after Mrs. Fourticq was admitted to the hospital but had existed for some time before. This is of course correct. But the broken hip, which required the emergency operation, did not exist when Mrs. Fourticq was admitted. It was literally a condition that developed after her admission.

Plaintiff's counsel suggested in oral argument that the fact that the bone fracture was unexpected, and that it unquestionably required immediate treatment, should control. He analogized Mrs. Fourticq's situation to that of a person who happens to suffer injury immediately outside a non-participating hospital, or in the lobby after having been discharged for unrelated treatment. Those are the types of emergency situations that the statutory exception appears precisely intended to cover; actually, the regulation was designed to distinguish those events from the type of emergency that arose in the instant case. For here, the emergent condition for which Mrs. Fourticq required extensive medical attention arose *after* her admission, not before. Indeed, it was directly related to and a consequence of the condition that led her to seek hospitalization originally. Any medical treatment that requires hospitalization, regardless of how minor it may appear initially, can result in an emergency situation: serious hemorrhaging may occur during a tonsillectomy, a patient having his wart removed may experience adverse reactions to even a local anesthetic, and a gastro-intestinal

X-ray series may reveal unsuspected serious conditions. This is, of course, even more likely where the patients are all elderly. The Medicare regulation is reasonable in distinguishing between the patient's active selection of a hospital, in the face of the possibility that more care may be needed than anticipated, and the accident of geography that causes an individual to require sudden emergency care in the vicinity of a non-participating hospital.

Nor does the fact that Mrs. Fourticq was suffering from a serious condition unknown to her physician before she entered the hospital change the result. The test adopted by the regulations is based entirely on the physician's assessment of his patient prior to the admission. If the doctor thinks the condition is an emergency, the fact that his concern is later proved unfounded does not deprive the patient of benefits.[5] Obversely, if he considers the patient's condition is not emergent, the fact that he learns of more serious ailments after hospitalization does not render the hospital admission itself retroactively emergent. The test adopted by the regulations is predicated on the doctor's diagnosis prior to admission an entirely reasonable standard. Nor is it inappropriate to emphasize, even at the expense of redundancy, that the crucial diagnosis is made by the patient's own attending physician, not someone in the government's employ.

As remedial social welfare legislation, "the Social Security Act is to be construed liberally to effectuate its general purpose of easing the insecurity of life," *Rodriguez* v. *Celebrezze*, 1 Cir. 1965, 349 F. 2d 494, 496. See also, e.g. *Rasmussen* v. *Gardner*, 1 Cir. 1967, 371 F. 2d 589, 594; *Walston* v. *Gardner*, 6 Cir. 1967, 381 F. 2d 580, 585; *Celebrezze* v. *Kilburn*, 5 Cir. 1963, 322 F. 2d 166, 168. But that does not mean the court must declare any regulation that leads to a denial of benefits to be invalid. Regulation § 405.191(b)(3) makes the existence or nonexistence of an emergency condition depend on the assessment contemporaneously made by the person who was then best qualified to make it, the patient's physician. This standard is, in the main, probably more generous to claimants than other criteria would be. At any rate, it is reasonable and fairly comports with that statute.

For these reasons, plaintiff's motion for summary judgment will be denied, and judgment will be entered for defendant, affirming the decision of the Appeals Council.

(X—Refer to SSR 71-38c)

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[5] While the finding that an emergency existed will ordinarily be based on the physician's statement concerning the patient's condition, a statement by the pyhsician or hospital that an emergency existed, in the absence of *sufficient medical information* to establish the actual emergency, will not constitute sufficient evidence of an emergency. (42 CFR 405.191(b)(1).) (Ed. Note)

SECTION 1814(d)—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—SURGERY PERFORMED 2 DAYS AFTER ADMISSION TO A HOSPITAL—NO LIFE SAVING OR EMERGENCY SERVICES REQUIRED OR RECEIVED.

42 CFR 405.152, 405.192 HCFAR 79–56

A hospital insurance beneficiary fell on June 10 and fractured her hip. She was admitted on June 11 to a hospital eligible for payment under title XVIII of the Social Security Act only for "emergency services." Although there was a participating hospital in the city where she lived, she was transported 30 miles to a nonparticipating hosptial in another city which also had three participating hospitals equally accessible as the one to which she was admitted. The required surgical procedure on her hip was not performed until June 13, 3 days after her accident and 2 days after admission to the hospital. No emergency procedures or life saving techniques were required or received by the beneficiary. *Held*, payment of hospital insurance benefits for the services furnished the beneficiary by the nonparticipating hospital beginning June 11 is precluded since such services did not constitute "emergency services" within the meaning of Section 1814(d) of the Social Security Act and Regulations of the Health Care Financing Administration.

On June 10, H, a hospital insurance beneficiary under title XVIII of the Social Security Act, fell while at home, breaking her hip. The following day she was admitted to the M Hospital, 30 miles from her home, where surgery was performed on her hip on June 13. A claim for payment pursuant to section 1814(d) of the Social Security Act, for the inpatient hospital services furnished H has been made by the M Hospital, a nonparticipating hospital which could claim payment under the Medicare program for emergency services only.

Section 1814(d)(1) of the Social Security Act provides, as pertinent here, that:

> Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements . . . with it, to an individual entitled to hospital insurance benefits . . . even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, . . .

The issue to be resolved in this case is whether the inpatient hospital services furnished H by the M Hospital beginning June 11 constitute "emergency services" within the meaning of section 1814(d) of the Social Security Act.

Section 405.152(b) of the Health Care Financing Administration Regulations (42 CFR 405.152(b)) defines "emergency services" for purposes of the hospital insurance program as:

> . . . those inpatient hospital services . . . and outpatient hospital . . . services . . . which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital . . . available and equipped to furnish such services. . . .

Section 405.192 of the Regulations (42 CFR 405.192) provides, in pertinent part:

> (a) *General*—Services, to be emergency services (as defined in section 405.152(b)), must be furnished by the most accessible hospital available and equipped to furnish such services.
>
> * * * * *
>
> (b)(2) . . . In urban and suburban areas, where both participating and nonparticipating hospitals are similarly available, it will be presumed that the services could have been provided in a participating hospital. This presumption can be overcome only by clear and convicing evidence showing the medical or practical necessity in each individual case for taking the patient to a nonparticipating hospital instead of a similarly available participating hospital.
>
> (b)(3) There are some situations requiring prompt removal of a patient to a hospital but in which there was no immediate need . . . . to rush the patient to a hospital, i.e., his condition, while requiring prompt attention in a hospital, indicated there was some time available to get him to one. In such cases the services provided in a nonparticipating hospital are not covered as emergency inpatient hospital services if there was a participating hospital in the same general area but further away from the place where the emergency occurred, provided that professional judgment confirms that the additional time required to take the patient to the participating hospital would not have been hazardous to the patient.

H's attending physician stated that since the services of a bone specialist were not available at the participating hospital in the town where she lived, it was necessary to transport her 30 miles to a hospital where such services could be secured.

Although it is clear that H required hospitalization as a result of her fall, there was adequate time available to get her to a participating hospital. She was not rushed to the nearest hospital but instead was able to tolerate a trip to a hospital 30 miles away on the following day. The record does not establish the need for any emergency procedures or life saving techniques upon H's admission to that hospital. On the contrary, the evidence shows that the surgical procedures for repair of her fractured hip was not undertaken until the third day after her injury occurred, and 2 days after her admission to the hospital. Further, at the time of H's admission to the M Hospital, there were three equally accessible participating hospitals in the same town, and the evidence shows that at least one of them had a bed available.

Since the facts in this case clearly fall within the contingencies contemplated by sections 405.192(b) and (b)(3) of the Health Care Financing Administration Regulations it is *held* that payment may not be made for the services furnished H by the M Hospital beginning June 11 since they did not constitute "emergency services" within the meaning of section 1814(d) of the Social Security Act and the regulations promulgated thereunder.

(X—Refer to SSR 71-39)

SECTION 1814(d) (42 U.S.C. 1395ff).—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—INPATIENT OF NONPARTICIPATING HOSPITAL FOLLOWING TERMINATION OF THE EMERGENCY PERIOD

42 CFR 405.152(b), 405.191–2 HCFAR 79–57

(This is a reprint of HCFAR 78-18(46) which updates certain references not included in the original printing.)

Where a hospital insurance beneficiary with congestive heart failure was admitted on January 15 to a hospital eligible for payment under title XVIII of the Social Security Act only for "emergency services" and remained there until her condition improved so that beginning January 18 she could have been transferred to a participating hospital without endangering her health, *held,* payment may be made to the hospital for the services furnished from January 15 through January 17 since such services constitute "emergency services" within the meaning of section 1814(d) of the Social Security Act. *Further held,* payment for the services provided after January 17 is precluded since the services did not constitute "emergency services" once her condition improved to the point where she could have been transferred to a participating hospital.

K, a hospital insurance beneficiary under Part A of title XVIII of the Social Security Act, entered the O Hospital on January 15 with an admitting diagnosis of arteriosclerotic heart disease with congestive heart failure. On January 23, K was discharged from the O Hospital which, although not participating as a provider of services under title XVIII of the Social Security Act, was eligible to receive payment for emergency services pursuant to section 1814(d) of the Act. A claim was filed for reimbursement for the services furnished K by the O Hospital from January 15 through January 23. Payment has been made only for the period January 15 through January 17 but has been denied for the remainder of the period, i.e., January 18 through January 23, on the grounds that K's emergency terminated January 17 and thereafter she could have been transferred to a participating hospital. K protested this decision; it was contended on her behalf that the Health Care Financing Administration erred in relying on its regulations published after her discharge from the hospital to make a determination in her case.

Section 1814(d) of the Social Security Act provides, as pertinent here, that payment for inpatient hospital services furnished an individual may be made to providers of services who, by agreement with the Secretary of Health, Education, and Welfare, are eligible to participate in the Medicare program under title XVIII of the Act. Payment will also be made to or on behalf of an individual, upon a claim for reimbursement, for inpatient hospital services furnished even though such hospital is not a fully participating provider under title XVIII, if among other requirements, the services were emergency services.

Section 405.152(b) of Health Care Financing Administration Regulation (42 CFR 405.152(b)), as pertinent here, defines "emergency services" as those inpatient hospital services which are necessary to prevent death or serious impairment to the health of an individual and which, because of

the threat to the life or health of an individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

Section 405.192 of the Regulations (42 CFR 405.192) provides, in pertinent part:

> (a) General.—Services, to be emergency services (as defined in section 405.152(b)), must be furnished by the most accessible hospital available and equipped to furnish such services.
>
> (b) Objectives.—The objective of the requirement in paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services provided by nonparticipating hospitals to situations where transport of the patient to a participating hospital would have been medically inadvisable, e.g., the participating hospital would have taken longer to reach and the patient's condition necessitated immediate admission for hospital services; and for so long as that condition precluded the patient's discharge or removal to a participating hospital.

Section 405.191; of the Regulations (42 CFR 405.191) states, in pertinent part:

> (a) General.—Payment to a nonparticipating hospital for emergency services (as defined in section 405.152(b)) can be made only for the period during which the emergency exists.
>
> * * * * *
>
> (2) An emergency no longer exists when it becomes safe from a medical standpoint to move the individual to a participating hospital or other institution, or to discharge him.

The issue to be determined in this case is whether payment of hospital insurance benefits may be made for the services K received from the O Hospital for the period January 15 through January 23. The answer to this depends upon whether the services were emergency services within the meaning of section 1814(d) of the Social Security Act and regulations promulgated thereunder. In addition, assuming the facts show that an emergency existed upon K's admission to the hospital, it must be resolved whether such emergency continued for the entire period of her confinement beginning January 15 and ending with her discharge on January 23.

The medical evidence shows that K's condition upon admission to the O Hospital on January 15 required emergency inpatient hospital services to prevent death or serious impairment to her health. However, the hospital records further show that by January 17 her condition had improved to the point where emergency services were no longer necessary and she could have been transferred to a participating hospital without danger to her health.

Although section 405.192 (42 CFR 405.192) of the Regulations, the pertinent provisions of the regulations, were not published in the Federal Register until July 3, after K's inpatient hospital stay, they became effective upon publication and are applicable to any case decided after that date, regardless of the day of hospital admission, the date on which the claim was filed, or the period for which the services were provided, since they

constitute a clarification of what had already been provided in the Social Security Act.

Accordingly, *held*, payment may be made on K's behalf to the O Hospital for the services furnished her from January 15 through January 17 since such services constituted "emergency services" within the meaning of section 1814(d) of the Social Security Act. *Further held*, payment is denied for the remainder of K's inpatient hospital stay, i.e., from January 18 through January 23, since the services did not constitute "emergency services" once her condition improved to the point where she could have been transferred to a participating hospital.

(X—Refer to SSR 71–56)

SECTION 1814(d) (42 U.S.C. 1395f(d))—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES

42 CFR 405.152(b), 405.191 and 405.192 HCFAR 79–58c

Pigford v. Mathews, USDC Southern Dist: Miss., Civil Action No. 1584(N) (8/14/75)

The claimant was admitted to a nonparticipating hospital for treatment of a fractured knee with surgery being performed 2 days later. No services were performed to prevent death or serious impairment of the health of the claimant upon admission to the hospital and the claimant could have been transferred to a participating hospital a day or two later when a medicare bed became available. In order to determine that emergency services were rendered the Secretary must find (1) that the patient's state of injury or disease is such that a health or life-endangering emergency existed with regard to the claimant's condition and, (2) that diagnosis or treatment was given at the most accessible hospital available and equipped to render such services. *Held*, reimbursement for the services performed by the nonparticipating hospital is precluded by section 1814(d) of the Social Security Act since the services were found not to be covered emergency services as defined in 42 CFR § 405.152(b).

NIXON, DISTRICT JUDGE:

This suit is brought pursuant to Section 1869(b) of the Social Security Act, 42 U.S.C. 1395ff(b) by Edith C. Pigford (hereinafter referred to as Claimant) to review a final decision of the Secretary denying her claim for payment for alleged emergency services furnished here by Jeff Anderson Memorial Hospital, Meridian, Mississippi, a nonparticipating hospital under the program of health insurance benefits of Title XVIII of the Act (also known as Medicare) during the period of her confinement from August 7, 1968 through October 4, 1968. This Court has justification under the above section, which provides for a judicial review of a final decision of the Secretary as to the amount of benefits payable under Part A of Title XVIII, with the jurisdictional requirement that the amount in controversy is $1,000.00 or more.

The Claimant entered Jeff Anderson Memorial Hospital in Meridian, Mississippi, a nonparticipating institution in the Medicare program, on

August 7, 1968 and remained through October 4, 1968. The total charges incurred for her were $2,765.40. She was admitted for treatment of a broken knee cap. Coverage was denied on the ground that the hospital services furnished to the Claimant were not emergency services as required under Section 1814(d) of the Act, 42 U.S.C. 1395f(d) for a nonparticipating hospital.

Reconsideration was requested and coverage was again denied. The Claimant requesting a hearing before a hearing examiner, which was held on December 4, 1969, and on December 23, 1969, the hearing examiner concluded that the services did not constitute emergency services, and affirmed the previous decision of the administration. The Claimant filed a request for a review before the Appeals Council and the Appeals Council declined review of the hearing examiner's decision on September 10, 1970.

The Claimant then sought review before this Court and by an order filed in this cause on June 16, 1971, the case was remanded to the Secretary for further hearing. The supplemental hearing was held on September 28, 1971 and on October 22, 1971 the hearing examiner recommended to the Appeals Council a finding that the services performed on behalf of the Claimant were not emergency services and that the Claimant was not entitled to Medicare payment. The Appeals Council adopted the findings and conclusions in the hearing examiner's decision, with one minor change, not pertinent to this decision, and is now before this Court again for review.

The operative facts are as follows. On August 7, 1968, the claimant was hospitalized at Jeff Anderson Memorial Hospital with a fractured knee. On the day of the admission, the Claimant, according to the physical examination taken at that time, was well-developed, well-nourished and in no acute pain with normal pulse and respiration and blood pressure of 160/70. Admission to the nonparticipating hospital was made because her physician certified that the Claimant required emergency services to prevent her death and there was no vacancy at the three other Medicare participating hospitals in Meridian, Mississippi. The Claimant was operated on two days after admission to the hospital and after a two month stay was finally released on October 5, 1968.

At the supplemental hearing held on September 28, 1971, affidavits were submitted and testimony taken. Dr. Med Scott Brown, the Claimant's physician, certified that she personally contacted the participating hospitals in the area and determined that no room was available; that after making this determination it was her medical opinion that the Claimant was in an emergency situation and it would have been a serious threat to the Claimant's health to require her to be moved from Jeff Anderson Memorial Hospital to a distant hospital, *outside the area of Meridian, Mississippi* (Emphasis supplied).

Dr. William L. Thornton, the operating physician, certified that he performed an operation on the Claimant's right tibia on August 9, 1968, and that, based on his consultation with Dr. Med Scott Brown and his examination of the Claimant, it would have been a serious threat to Claimant's health to have moved her from the nonparticipating hospital to a Medicare participating hospital.

Dr. Wildridge C. Thompson testified at the supplemental hearing as a

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medical advisor. He stated that on August 7, 1968, the date the Claimant was hospitalized and two days before the surgery was performed, she could have been transferred to a participating hospital within Meridian without hazard. He further testified that, after surgery, there would have been a period of from one to two weeks when a transfer would not have been advisable. Dr. Thompson further testified that her condition was one which had to be attended to within two or three days but not within two or three hours following her admission and it would not have endangered the life of the Claimant or materially have worsened her condition for her to be transferred prior to the operation on her knee.

There were also statements from the three Medicare participating hospitals in Meridian, Mississippi to the effect that a bed was available in each of said institutions on August 7 and August 8, 1968, and a Medicare patient would have been accepted.

The sole issue before this Court is whether the Claimant is entitled to hospital insurance benefits under the Act for emergency services. In order for her to be entitled to reimbursement, a medical emergency must have existed in the instant case, since she was taken to, and treated at, a non-participating hospital [Section 1814(d) of the Act, 42 U.S.C. 1395f(d)]. The term emergency services is defined in Section 405.152(b) of the Regulations of the Social Security Act as "those inpatient hospital services * * * which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life and health of the individual, necessitate the use of the most accessible hospital (see Section 405.192) available and equipped to furnish such services * * *." Section 405.192 sets forth rules for use in making a finding of whether the services performed are emergency services. The Regulation notes that time is a crucial factor and the patient must ordinarily receive hospital care as soon as possible. In this case, the Claimant was not operated on until two days after her admission and this Court cannot hold that the services rendered come within the definition of emergency services.

The scope of judicial review of the Secretary's decision is narrowly limited to the issue of whether fact determinations are supported by substantial evidence. 42 U.S.C. 405(g); *Hayes v. Celebrezze*, 311 F. 2d 648 (5 Cir. 1963); *Richardson v. Richardson*, 437 F. 2d 109 (5 Cir. 1970) and *Burdett v. Finch*, 425 F. 2d 687 (1970). Even if this Court, hearing the same evidence *de novo*, might have held otherwise, the findings of the Secretary are conclusive if supported by substantial evidence. *Robinson v. Celebrezze*, 326 F. 2d 840 (5 Cir.), *cert. den.* 379 U.S. 851 (1964); *Brown v. Celebrezze*, 347 F. 2d (5 Cir. 1964). Credibility findings as to any conflicts in the evidence are to be made by the Secretary and not by the trial court. *Celebrezze v. Zimmerman*, 339 F. 2d 496 (5 Cir. 1964); *Stillwell v. Cohen*, 411 F. 2d 574 (5 Cir. 1969).

After a careful review of the records, this Court is of the opinion that the findings of the hearing examiner, as recommended to the Appeals Council and adopted by it, are supported by substantial evidence and that

the proper legal standards were applied.* The decision of the Secretary is therefore affirmed and this motion for summary judgment on behalf of the Secretary of Health, Education, and Welfare is granted.

(X—Refer to SSR 76–17c)

SECTION 1814(d)—HOSPITAL INSURANCE BENEFITS—EMERGENCY SERVICES—ACCESSIBILITY REQUIREMENT

42 CFR 405.152(b) and 42 CFR 405.192 HCFAR 79–59

A hospital insurance beneficiary after suffering an acute myocardial infarction in her home was transported by ambulance 105 miles and admitted to a nonparticipating hospital eligible for payment under title XVIII of the Social Security Act only for emergency services. There are 4 participating hospitals available and equipped to furnish the emergency services required by the claimant, 3 in the same city as the hospital to which the beneficiary was admitted, the other, 63 miles from the beneficiary's home where the emergency occurred. There is no clear and convincing evidence showing the medical or practical necessity for taking the patient to the nonparticipating hospital, which furnished the emergency services. *Held,* payment may not be made to the nonparticipating hospital for the inpatient services it provided, since these services were not provided by the most accessible hospital available and equipped to furnish "emergency services" within the meaning of section 1814(d) of the Social Security Act.

H, a hospital insurance beneficiary under part A of title XVIII of the Social Security Act, was taken from her home by ambulance to the Q Hospital, a nonparticipating hospital, in a city over 100 miles away, after suffering an acute myocardial infarction. She remained there until her death 10 days later. A claim for payment pursuant to section 1814(d) of the Social Security Act, has been made for the inpatient hospital services furnished H by the Q Hospital, which is eligible for payment under the program only for emergency services. Section 1814(d)(1) of the Social Security Act provides, as pertinent here, that:

> Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements . . . with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, . . .

The issue to be resolved in this case is whether the inpatient hospital services provided H by the Q Hospital constitute "emergency services" within the meaning of section 1814(d) of the Social Security Act. The answer to this depends upon whether these services were furnished in the most accessible hospital available and equipped to furnish them.

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* The court implicitly accepted, as supported by substantial evidence, the resolution by the hearing examiner and Appeals Council of conflicting testimony regarding the availability of beds in participating hospitals in favor of the Secretary. (Ed.)

"Emergency services," for purposes of the hospital insurance program, are defined in section 405.152(b) of Health Care Financing Administration Regulations (42 CFR 405.152(b)) as those inpatient hospital services "which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital . . . available and equipped to furnish such services."

Section 405.192 of the Regulations (42 CFR 405.192) provides, in pertinent part, as follows:

(a) *General.*—Services, to be emergency services as defined in § 405.152 (b), must be furnished by the most accessible hospital available and equipped to furnish such services.

(b) *Objectives.*—The objective of the requirement in paragraph (a) of this section is to limit reimbursement for emergency inpatient hospital services provided by nonparticipating hospitals to situations where transport of the patient to a participating hospital would have been medically inadvisable, e.g., the participating hospital would have taken longer to reach and the patient's condition necessitated immediate admission for hospital services; and for so long as that condition precluded the patient's discharge or removal to a participating hospital.

(1) In emergency situations, time is a crucial factor and the patient must ordinarily receive hospital care as soon as possible. Under such circumstances, all factors must be considered which bear on whether or not the required care could be provided sooner in the nonparticipating hospital than in a participating hospital in the general area. The determination must take account of such matters as relative distances of the participating and nonparticipating hospitals, the transportation facilities available to these hospitals, the quality of the roads to each hospital, the availability of beds at each hospital, and any other relevant factors. All of these factors are pertinent to a determination of whether a hospital is "the nearest," or "further away," or "closer to" the place where the emergency occurred.

(2) The consideration referred to in subparagraph (1) of this paragraph are generally applicable to rural areas, where hospitals are likely to be spaced far apart. In urban and suburban areas, where both participating and nonparticipating hospitals are similarly available, it will be presumed that the services could have been provided in a participating hospital. This presumption can be overcome only by clear and convincing evidence showing the medical or practical necessity in each individual case for taking the patient to a nonparticipating hospital instead of a similarly available participating hospital.

* * * * *

(4) The determination whether the nonparticipating hospital which claims reimbursement is the most "accessible" hospital will be made on the basis of the considerations set forth in paragraphs (c) and (d) of this section; interpreted in accordance with the statement of objectives in this paragraph (b). The personal preference of a patient, or of his physician, or of members of his family, or others, in the selection of a hospital, will not be considered a factor in determining whether services were furnished by the most accessible hospital. Nor will the nonavailability of staff privileges to the attending physician in a participating hospital which is available and most accessible to the patient, or the location of previous medical records, be considered a factor in the determination of accessibility.

(c) *Conditions Under Which the Accessibility Requirement Will Be Met.*—Where an individual must be taken to a hospital immediately for required

diagnosis or medical treatment, the accessibility requirements will be met, except as provided in paragraph (d) of this section, if it is established to the satisfaction of the Administration that:

(1) The nonparticipating hospital which furnished the emergency services is the nearest hospital to the point at which the emergency occurred (subject to the presumption contained in paragraph (b)(2) of this section); and, if there is a similarly available participating hospital, the evidence shows the medical or practical necessity for taking the patient to a nonparticipating hospital; or

(2) One or both of the following reasons apply:

(i) No closer participating hospital has a bed available or will accept the individual; or

(ii) The nonparticipating hospital is the nearest one equipped medically to deal with the type of emergency involved; or it is the nearest hospital which is equipped to handle the emergency which had a bed available when the emergency occurred.

(d) *Conditions Under Which the Accessibility Requirement Will not Be Met.*—The accessibility requirement will not be met if:

(1)(i) The diagnosis in the emergency claim or other evidence indicates there was some time for getting the individual to a hospital, and no immediate need to rush him to one; and

(ii) There is a participating hospital in the area which is further away from the point at which the emergency occurred than the nonparticipating hospital, but is equipped to handle such an emergency; and

(iii) The additional time it would have required to take the individual to the participating hospital would not have been hazardous to the patient; or

(2) There is a participating hospital, equipped to handle the emergency with a bed available, closer to where the emergency occurred than the nonparticipating hospital in which the beneficiary received emergency services; and neither of the reasons described in paragraph (c)(2) of this section apply.

When H suffered an acute myocardial infarction on August 5 at her home, she was examined by her two personal physicians and taken by ambulance 105 miles to the coronary care unit in the Q Hospital, a nonparticipating hospital at that time. Although H was furnished intensive coronary care, her clinical course was complicated by an acute hemorrhagic pancreatitis, shock, and congestive heart failure, and she died 10 days later. H's two attending physicians stated approximately 1½ months after her death that she was admitted to the coronary care unit of the Q Hospital on their orders since they were familiar with the excellent work being done there and the reputation of the physician-in-charge. They stated they were not aware of any other facility nearby available and equipped to furnish the required services.

It is evident from the record that H required immediate hospitalization for her condition on August 5, and that she needed intensive, life-saving procedures. However, for the definition of "emergency services" to be met, the additional requirement of accessibility must be met, i.e., the services must be furnished by the most accessible hospital available and equipped to furnish such services. It was not shown that the claimant required unique emergency procedures not ordinarily available in most hospitals—participating or nonparticipating.

Although time was of the essence, H was transported 105 miles by ambulance. Her two physicians made this choice because they knew of the

coronary care unit in the Q Hospital and of the work of the physician-in-charge.

The State Department of Hospitals indicated that 4 participating hospitals, 3 in the same city as the Q Hospital and one 63 miles from her home, had a bed available on August 5, and were equipped with an intensive care unit or a coronary care unit and were properly equipped to handle complications arising from acute myocardial infarction.

Assuming that these four participating hospitals were equipped with intensive care units on August 5 rather than coronary care units and although it may well be desirable to have all of the facilities of a coronary care unit available, it is not unreasonable to find that participating hospitals with intensive care units are able to take care of patients with acute myocardial infarctions without the specific coronary care unit but with basically the same equipment and personnel available for such care.

Based on the facts in this case it is clear that the four participating hospitals were equipped medically to handle H's emergency on August 5, and had beds available on that date. The three hospitals in the same city as the nonparticipating Q Hospital were equally as accessible and in view of the presumption established under section 405.192(b)(2) of the Regulations it appears that H could have been transported to one of these three hospitals, or to the hospital located only 63 miles from H's home where the emergency occurred. Therefore, the accessibility requirement would not be met. In addition, under section 405.192(b)(4) of the Regulations, the personal preference of the claimant's physicians in the selection of Q Hospital cannot be considered a factor in determining whether services were furnished by the most accessible hospital.

Therefore, since the services in question were not furnished by the most accessible hospital available and equipped to furnish such services, it is *held* that H was not provided "emergency services" within the meaning of section 1814(d) of the Social Security Act by the Q Hospital during the period of August 5 to August 15. Thus payment of hospital insurance benefits may not be made for the inpatient services provided her during this period of hospitalization.

(X—Refer to SSR 72-9)

SECTIONS 1814(b)(1) and 1861(v)(1)(A) (42 U.S.C. 1395f(b)(1) and 1395x(v)(1)(A))—HEALTH INSURANCE BENEFITS—REASONABLE COST—RELATED PARTY SUPPLIER

42 CFR 405.427 HCFAR 79–60c

Fairfax Hospital Association, Inc., V. Califano, USCA, Fourth Circuit, CA No. 77–1552, (9/19/78)

A pharmacy company owned by one of the organizers and directors of a hospital corporation entered into an agreement with the hospital to operate the hospital's pharmacy. The Medicare fiscal intermediary disallowed certain amounts claimed by the hospital as reimbursable costs, on the basis that the hospital was related to the pharmacy company. Under the applicable regulation (42 C.F.R. 405.427), the hospital could not claim as a cost charges for pharmacy services and supplies furnished to a related party.

The hospital appealed to the Provider Reimbursement Review Board (PRRB), which reserved the intermediary's determination. The PRRB found that the intermediary had the burden of proving by "compelling or conclusive evidence" that the hospital was related to the pharmacy company.

The Secretary subsequently reversed the PRRB's decision, and the hospital filed suit in Federal District Court.

In affirming the district court's decision in favor of the Secretary, the Court of Appeals *held* that the Secretary has the statutory authority to establish by regulation the method or methods to be used in computing "reasonable costs" for Medicare reimbursement purposes. The regulation (42 C.F.R. 405.427) concerning transactions between related parties violates neither the due process clause nor the equal protection clause of the Constitution because the classification in the regulation is rationally related to the prevention of abuses of Medicare reimbursement through use of manipulated charges by related suppliers and providers. *Further held,* that the PRRB erred in placing on the intermediary the burden of proving that the hospital's claim for reimbursement was not allowed under the regulations, since the hospital had the burden of establishing the allowability of its claim. *Further held,* that the PRRB followed an incorrect standard of proof in holding that the intermediary had to prove by "compelling or conclusive evidence" that the two organizations were related within the meaning of the regulation, and that in administrative proceedings the proponent of any fact need only establish it by a preponderance of the evidence. *Further held,* that the Secretary is not limited in his review to a determination as to whether the PRRB's decision is supported by substantial evidence when the record is viewed as a whole; but that the Secretary has all the usual powers that an agency head exercises in administrative proceedings, including the right to review the PRRB's findings of fact.

RUSSELL, Circuit Judge:

The plaintiff/appellant, a private provider of hospital services to the aged, has appealed from a decree of the District Court, granting summary judgment for the defendant/appellee, and sustaining a decision of the Commissioner of Social Security, under valid delegation from the Secretary of Health, Education and Welfare, denying reimbursement for certain costs claimed by the appellant in furnishing services under the "Medicare" program.[1] We affirm largely on the well-reasoned opinion of the District Court.[2]

The Medicare program for the aged and disabled, under which this controversy arises, is administered by a combination of private and governmental organizations or entities. Those who are eligible for benefits under the program are given treatment or care by a qualified "provider of services" such as the appellant hospital in this case.[3] The provider is paid, not by the patient-beneficiary but out of the Federal Hospital Insurance Trust Fund.[4] In administering the program, the Government operates generally through what are called fiscal intermediaries.[5] These are private organizations functioning under contract with the Secretary of HEW, or his delegate.[6] They make interim estimated payments to the providers on a monthly basis, subject to subsequent adjustment for over-payment or under-payment.[7]

At the end of the provider's fiscal year, the fiscal intermediary reviews the provider's cost report setting forth the latter's claims for reimbursement over the preceding fiscal year, audits the claims included therein if it deems this necessary and, as a result of that review, advises the provider

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[1] This program is officially denominated in the statute as Health Insurance for the Aged and Disabled. § 1395, *et seq.*, 42 U.S.C.

[2] *Fairfax Hospital Ass'n., Inc. v. F. David Mathews, Secretary* (E.D. Va. 1977) F. Supp. (decided February 18, 1977).

[3] A "provider of services" under the Act "means a hospital, skilled nursing facility, or home health agency, or, for purposes of section 1395(f)(g) and section 1395n(c) of this title, a fund." § 1395x(u), 42 U.S.C.

[4] 1395g, 42 U.S.C.

[5] 1395h(a), 42 U.S.C. This section provides:

> "If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1395oo of this title and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers."

[6] The Secretary of HEW at the time of the challenged decision had delegated his functions under the Act to the Commissioner of Social Security. 33 F.R. 5836 (1968). For the validity of such delegation, *see Pacific Coast Medical Enterprises v. Califano* (C.D. Cal. 1977) 440 F. Supp. 296, 305.

[7] §§ 1395g and 1395x(v)(1)(A)(ii); 20 C.F.R. §§ 405.402(b)(1), (2) and 405.454. (Ed. Note—Effective Sept. 30, 1977, Medicare program regulations were recodified in 42 C.F.R. Part 405.)

if it makes a determination in connection with such review of either over-payment or under-payment to the provider during the year reviewed. This determination is formally set forth in a Notice of Program Reimbursement.[8] As a result of this determination, the fiscal intermediary may find certain payments not properly reimbursable in whole or in part and it may call for repayment by the provider for any interim over-payments found to have been made during the year. If the fiscal intermediary finds reimbursement of an item improper in this review, the provider may, should it be dissatisfied with the finding, request a hearing before the Provider Reimbursement Review Board (PRRB), provided the amount of the claim exceeds $10,000.[9] The decision of the Board, entered after a hearing, is final unless the Secretary "on his own motion" reverses or modifies it.[10] From the decision of the Board, if it is not reversed or modified by the Secretary, or from the ruling of the Secretary, if he has reversed or modified the Board's decision, there is a right of judicial appeal on the part of the provider to the District Court.[11]

The appellant hospital is a provider under the program. As a result of a review by the fiscal intermediary servicing the appellant's reimbursements for the fiscal year 1973, charges for pharmacy supplies furnished the provider by Virginia Medical Supply, Inc. for the first eight months of 1973 were disallowed to such extent as those charges exceeded costs of the supplies to Virginia Medical Supply, Inc. Similarly, the management fees paid in connection with the operation of the pharmacy supply house for the last four months of 1973 to Gunther K. Kessler and Associates, Inc. were reduced to the actual amount required to operate the pharmacy, plus reasonable compensation. The net reductions thus made in reimbursements to the appellant aggregated approximately $17,500. The basis of such disallowances was a regulation of the Secretary which fixed the amount of reimbursable costs for supplies furnished the provider when the provider and supplier are related by either "common ownership" or "common control." The statutory authority for this regulation, as asserted by the Secretary is § 1395x(v)(1)(A), 42 U.S.C.:

> "The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs * * *."

The fiscal intermediary determined that the Commonwealth Doctors Hospital, Inc.,[12] the provider, and the Virginia Medical Supply, Inc. and Gunther K. Kessler Associates, Inc. were under common control and that services furnished by the Virginia Medical Supply, Inc. and/or Gunther K.

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[8] 20 C.F.R. § 405.1803.

[9] § 1395oo(a), 42 U.S.C.; 42 C.F.R. § 405.1835.

[10] § 1395oo(f), 42 U.S.C.

[11] *Ibid.*

[12] The appellant Fairfax Hospital Associates, Inc. is the successor in interest of Commonwealth Doctors Hospital, Inc.

Kessler Associates, Inc. to the provider were reimbursable, not on the basis of charges made by the related supplier to the provider, but on the basis of the actual costs to the related supplier of the pharmacy supplies furnished the provider in the case of the Virginia Medical Supply, Inc. and on the basis of operating cost plus reasonable compensation in the case of the Associates. After a hearing, as requested by the provider, the PRRB filed its decision finding that the intermediary "did not produce compelling or conclusive evidence that the Pharmacy Owner did in fact exercise 'legal or effective control' over the Provider's actions or policies within the meaning of § 405.427(b)(3) of the Regulations" and accordingly "conclude[d] that the Provider is entitled to the inclusion of the pharmacy and management charges." The Secretary, however, "on his own motion," reversed that decision of the PRRB and found that the parties were "related" within the terms of § 405.427, 20 C.F.R. From that ruling of the Secretary, the appellant has appealed.

The appellant's first claim of error relates to the validity and legitimacy of the Regulation dealing with the reimbursement for charges between "related" parties under the Medicare program. This Regulation defines "related to the provider" as meaning "that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." [13] Control, as used in the Regulation, is defined in turn as existing "where an individual or organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." [14] But the Regulation refines further its definition of "related" control by excepting from its operation any purchases by the provider from "related" supplier if the provider "demonstrates by convincing evidence * * * [a] that the supplying organization is a bona fide separate organization; [b] that a substantial part of its business activity of the type carried on with the provider is transacted with others than the provider * * * and there is an open, competitive market for the type of services, facilities, or supplies * * *; [c] that services, facilities, or supplies are those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and [d] that the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market * * *." [15] As applied the Regulation treats items supplied a provider by a "related supplier," as if "the items [were] obtained from itself" in the calculation of costs under the reimbursement provisions of the program.[16]

There can be no disputing the Secretary's statutory authority to define by regulation the method of computing "reasonable cost" for charges for which a provider such as the appellant seeks reimbursement under the

[13] 20 C.F.R. § 405.427(b)(1).
[14] 20 C.F.R. § 405.427(b)(3).

[15] 20 C.F.R. § 405.427(d).
[16] 20 C.F.R. § 405.427(c)(2).

Medicare program, nor the power of Congress to clothe the Secretary with the power to exercise that authority.[17] Such authority is plainly set forth in the statute. Thus, the statute expressly delegated to the Secretary the right to issue regulations "establishing the method or methods to be used" in computing such "reasonable cost." [18] In exercising that right, the Secretary could unquestionably classify, as he has often done,[19] the charges as made by various types of suppliers and fix the "reasonable cost" allowable for suppliers whose charges were within a particular classification. So long as it is not "a patently arbitrary classification, utterly lacking in rational justification" [20] and based on a state of facts which could not "reasonably * * * be conceived to justify it," [21]—so long as "the goals sought are legitimate and the classification adopted is rationally related to the achievement of those goals," [22]—the classification will not be found constitutionally invalid.

In order to satisfy these requirements for constitutionality, the classification, it has been repeatedly said, need not be perfect or "made with mathematical nicety" nor will it be flawed constitutionally if "in practice it results in inequality." [23] Particularly in a program as complex as the Medicare program, with its large numbers of providers and suppliers and with its wide range of suppliers and services, the Secretary, in his regulations may make, indeed he must make, "rough accommodations-illogical it may be, and unscientific," [24] using generalized classifications governing the methods of calculating "reasonable cost" when it is obvious that individualized cost calculations are both not administratively practical and unduly expensive.[25] It has been said that the true test for ascertaining the validity of a classification fashioned to control excessive costs under the Medicare program is whether it can be said that the Secretary "could rationally have concluded both that a particular limitation or qualification

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[17] *Randolph v. United States* (3-judge Ct. N.C. 1967) 274 F. Supp. 200, 204, *aff'd.* 389 U.S. 570 (1968).

[18] § 1395x(v)(1)(A), 42 U.S.C.

[19] *See, St. Louis Univ. v. Blue Cross Hosp. Serv.* (8th Cir. 1976) 537 F.2d 283, 286, *cert. denied* 429 U.S. 977; *Whitecliff, Inc v. United States* (Ct. Cl. 1976) 536 F.2d 347, *cert. denied* 430 U.S. 969 (1977); *Chelsea Community Hospital v. Michigan Blue Cross* (E.D. Mich. 1977) 436 F. Supp. 1050.

[20] *Flemming v. Nestor* (1960) 363 U.S. 603, at 611, *reh. denied* 364 U.S. 854.

[21] *McGowan v. Maryland* (1961) 366 U.S. 420, 426, cited and quoted in *Dandridge v. Williams* (1970) 397 U.S. 471, 485.

[22] *Richardson v. Belcher* (1971) 404 U.S. 78 at 84, quoted with approval in *Weinberger v. Salfi* (1975) 422 U.S. 749, at 768–769.

[23] *Dandridge v. Williams, supra,* at 485 (397 U.S.). *See, also, Knebel v. Hein* (1977) 429 U.S. 288 at 294:

> "The District Court was correct that the regulations operate somewhat unfairly in appellee's case. Nevertheless, we are satisfied that they are the product of a valid exercise of the Secretary's statutory authority. Perhaps it might have been more equitable to allow a deduction for all commuting expenses, or for the expenses of commuting to a training program, or—as the order of the District Court provides—just for such expenses covered by state transportation allowances. But the availability of alternatives does not render the Secretary's choice invalid."

[24] *Dandridge v. Williams, supra,* at 845 (397 U.S.).

[25] *Weinberger v. Salfi, supra,* at pp. 773–780 (422 U.S.).

would protect against [the potential abuse] and that the expense and other difficulties of individual determinations justified the inherent imprecision of a prophylactic rule" protecting against such abuse. Such is the test as stated in *Weinberger v. Salfi, supra,* at pp. 777 and 785 (422 U.S.). So judged, the Regulation under review here satisfies constitutional requirements.

The appellant concedes the first predicate for the challenged Regulation, which is "that there is a potential for abuse [in connection with charges under the Medicare program] between related suppliers and providers." If it be accepted that there is "a potential for abuse" in charges made between "related" supplier and provider it follows that the Secretary has authority to formulate regulations and to prescribe reasonable classifications to prevent such abuse. In the oft-quoted language of *Williamson v. Lee Optical Co.* (1955) 348 U.S. 483, 488, "[i]t is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure [or administrative regulation] was a rational way to correct it." And that is just what the challenged Regulation purports to do, *i.e.,* to prevent a clearly perceived possible abuse through non-competitive, exclusive purchase and sale arrangements between a provider and supplier either of which has "the power, directly or indirectly, significantly to influence or direct the actions" of the other. In considering the Regulation as a reasonable effort to achieve this purpose, it is also important to note the restraint with which it is phrased in order to avoid the possibility of unfairness in its application. The Regulation did not cover charges by any and all suppliers, which had significant power to influence, or were subject to significant power to influence transactions between provider and supplier. It restricted its application to charges by that specific related supplier, who carried on no substantial business of the type carried on with the provider with any other organization and which was furnishing the provider supplies that a provider normally and customarily purchased directly and not from an intermediate supplier. Charges for supplies furnished by such a "related supplier," under the Regulation, would not be reimbursable at a price greater than would have been the costs of such supplies had the hospital-provider followed the customary practice of hospital-providers and purchased such supplies direct.

What in essence the Regulation did was to declare that, in computing the "reasonable cost" to a "related" hospital-provider for pharmaceutical supplies as in this case, the Secretary would reimburse that hospital-provider for those supplies at the price which normally hospitals similar to the "related" hospital-provider seeking reimbursement paid and not, for instance, at a price charged by the typical regular retail pharmacy serving a large number of customers purchasing individually. Stated somewhat differently, the Regulation was intended to prevent hospital-providers from departing from the customary method of purchasing direct pharmaceutical supplies and from inflating unfairly the charge to the Government for pharmaceutical supplies furnished its Medicare patients by what could be regarded as manipulated purchases of such supplies at a retail price from a "captive" pharmacy operated merely to serve as a supplier to the hospital selling under an exclusive, long-term non-competitive lease, and sub-

ject to the control test under the Regulation. We find nothing irrational or violative either of Due Process or Equal Protection in such Regulation, hedged about as it is by a reasonable exception.[26]

The suggestion of the Appellant that the Secretary exceeded his authority to prescribe by regulation "the method or methods to be used" in computing reasonable cost by providing for the sanctioning and control of "reasonable cost" on the basis of the relationship of the buyer and seller is supported by no logic or reason. It is little more than an argument—at least in this case—that the Government is absolutely obligated to reimburse a provider-hospital for purchases made by it from a "related" supplier even if the price for such purchases is substantially above what the provider, if it had followed the normal practice of a hospital-provider and bought directly, would have had to pay. The argument falsely assumes that the power to prescribe "reasonable cost" does not carry with it the power to determine what are not "reasonable costs." Following this reasoning, the appellant would contend that, even though the well established market price for an article under normal purchasing practices was one price but the provider chose to buy the same article from a favored supplier under an unusual arrangement at a much higher price, the Government may not, in assessing "reasonable cost," deny reimbursement at the unnecessarily higher price. The argument is completely without merit. Under this reasoning, the Government would be compelled to "reimburse the provider for all costs, no matter how extreme." [27]

Nor are we persuaded that the Regulation creates an unconstitutional irrebutable presumption. The doctrine of impermissible irrebutable or conclusive presumption has been justly criticized as of doubtful constitutional antecedents and of limited application.[28] It has been aptly observed that if the doctrine were strictly applied, it would "severely restrict the ability of legislatures to draft statutes that [can] be effectively administered," [29] and would operate as "a virtual engine of destruction for countless legislative judgments which have heretofore been thought wholly consistent with the Fifth and Fourteenth Amendments to the Constitution." [30] Its consistent application could, as Chief Justice Burger observes in his dissent in *Vlandis v. Kline* (1973) 412 U.S. 441 at 462, invalidate a state statute providing that one "may not be licensed to practice medicine or law unless he or she is a graduate of an accredited professional graduate school," it would, as a commentator has suggested, invalidate section 16(b)

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[26] To the same effect, *see, Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co.* (E.D. Wis. 1970) 311 F. Supp. 405, 411 ("The distinction which the regulation draws between the situations of related and non-related organizations has a rational basis." *Chelsea Community Hospital v. Michigan Blue Cross, supra,* at 1056, n. 2 (436 F. Supp.)

[27] *See, Pleasantview Convalescent, Etc. v. Weinberger* (7th Cir. 1976) 565 F.2d 99, 103.

[28] The author of Note, *The Conclusive Presumption Doctrine: Equal Process or Due Protection?* 72 *Mich. L. Rev.* 800, 827. (1974) states:

> "Perhaps the most serious defect in the conclusive presumption doctrine is that it rests upon a disingenuous, misleading analysis."

[29] *Ibid.* at 834.

[30] *Salfi, supra,* at 772 (422 U.S.).

of the Securities Exchange Act and even a state statutory speed limit.[31] For this reason, it has been suggested that courts should "abandon [their] 'war on irrebutable presumptions' as theoretically unsound and practically unworkable." [32]

Nor has the doctrine been given more than a limited application by courts. The commentator in 72 *Michigan Law Review*, after reviewing all the cases in which the doctrine was stated, found that "[t]he conclusive presumption doctrine has been applied exclusively in cases that involved overinclusive burdening classifications," and he concludes that, "[i]f the doctrine is to be manageable any future use must be limited to its past role as a hardship exception to established equal protection precedent." [33] In *Weinberger v. Salfi*,[34] The Court after reviewing the authorities in which the doctrine had been cited, found that all cases, where the doctrine had been referred to, could be classified under two groups: Either as cases in which the challenged regulation or statute was not rationally related to the object of the regulation or statute (a typical ground for invalidating a classification) [35] or as a case involving a fundamental constitutional right (a classification which corresponded to the extreme hardship case noted in the comment *supra*).[36] It then proceeded to dismiss the irrebutable or conclusive presumption doctrine as entirely inapposite in reviewing for constitutionality statutes or regulations involved in "social welfare legislation" and to reaffirm the rule in that area as declared in *Richardson v. Belcher, supra* (404 U.S. 78); *Dandridge v. Williams, supra* (397 U.S. 471) and *Flemming v. Nestor, supra* (363 U.S. 604), to wit: So long as a claimant for benefits or payments under a social welfare program is "free to present evidence" that he is not disqualified under the test established by the statute or regulation, his "only constitutional claim is that the test [he] cannot meet is not so rationally related to a legitimate legislative objective that it can be used to deprive [him] of benefits available to those who do satisfy that test." [37]

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[31] Note, *ibid.*, 72 *Mich. L. Rev.* at 832–3.

[32] Note, *ibid.*, 72 *Mich. L. Rev.* at 834.

[33] Note, *ibid.*, 72 *Mich. L. Rev.* at 829, 830.

[34] 422 U.S. at 772–773.

[35] *U.S. Dept. of Agriculture v. Murry* (1973) 413 U.S. 508, 514 (classification irrational for making "the issue * * * not the indigency of the child but the indigency of a different household"); *Jimenez v. Weinberger* (1974) 417 U.S. 628, 630 (the issue of the case, as stated by the court was whether "the statute's classification is rationally related to the legitimate governmental interest of avoiding spurious claims.")

Vlandis v. Kline, supra (412 U.S. 441) is not included in this list in *Salfi* but in *Sosna v. Iowa* (1975) 419 U.S. 393 at 409, *Vlandis* is also catalogued as a case in which the Court found the statute irrational. That is obvious as *Sosna* points out, because the Court said it was not finding unconstitutional "a *reasonable* durational residency requirement," from which the inescapable deduction is that the challenged statute established an unreasonable irrational residency requirement; (Italics added) *see, also, Usery v. Turner Elkhorn Mining Co.* (1976) 428 U.S. 1 at 22; *Lavine v. Milne* (1976) 424 U.S. 577 at 584–5, n. 9.

[36] *Stanley v. Illinois* (1972) 405 U.S. 645, 651 (an "essential" right "far more precious * * * than property rights"); *Cleveland Board of Education v. LaFleur* (1974) 414 U.S. 632, 639–640, (right involved "one of the liberties protected by the Due Process Clause of the Fourteenth Amendment.")

[37] *Weinberger v. Salfi, supra,* at 772 (422 U.S.).

The rule thus declared in *Salfi* has been recently reaffirmed in *Knebel v. Hein*,[38] which involved a regulation of the Secretary of Agriculture issued under the Food Stamp program. That regulation, in fixing the amount an eligible householder had to pay for food stamps by the householder's income, defined income to include transportation allowances received in attendance at a training school. The allowance in the particular case was conceded to be less than the actual cost of transportation. As a result of the inclusion, the householder had his price for food stamps increased. The householder contended the regulation resulted in a conclusive presumption that the transportation allowance was income, a presumption which in the particular case was not true in fact. After observing that the challenged regulation "operate[d] somewhat unfairly in appellee's case," the Court sustained the regulation, saying (p. 297):

> "Nor do the regulations embody any conclusive presumption. They merely represent two reasonable judgments: first, that recipients of state travel allowances should be treated like other trainees and like wage earners; and second, that the standard 10% deduction, coupled with the 30% ceiling on coupon purchase prices, provides an acceptable mechanism for dealing with ordinary expenses such as commuting. The Constitution requires no more. See *Salfi, supra* at 771, 777."

And the rule as stated in *Salfi* and *Knebel* was applied in connection with this very Regulation in *Chelsea Community Hospital v. Michigan Blue Cross, supra*.[39] There the Court confronted a challenge to the Regulation under the irrebutable presumption doctrine. After reviewing the authorities, it concluded that the doctrine had been either "ignored or distinguished on questionable grounds" in recent cases and had been specifically dismissed as a ground for invalidating a regulation such as § 405.427, 20 C.F.R., issued as that regulation was in the social service area. In so doing it followed the earlier decision in *Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co., supra*.[40] We are in agreement with those decisions.

The appellant here does not deny that it was free to present evidence that it was not disqualified under the Regulation it attacks. In fact, it did offer such evidence. Under *Salfi*, its only constitutional claim under those circumstances could be that the regulation was not rationally related to the legitimate objective of preventing abuse in charges between "related" providers and suppliers. For the reasons already given, that it cannot do in this case, and its challenge to the Regulation must fail.

The appellant next directs its attack at the Secretary's power of review, and in this it is joined by the *amicus, Federation of American Hospitals*. Its contention in this regard is based on a construction of the statute creating the Provider Reimbursement Review Board, § 1395oo, 42 U.S.C. This Board was created in 1972, with its members appointed by the Secretary

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[38] 429 U.S. 288.

[39] 436 F. Supp. 1050, 1062.

[40] 311 F. Supp. 405.

for fixed terms, for the purpose of providing a form of appeal "by a provider of services of a fiscal intermediary's final reasonable cost determination." [41] Decisions of the Board were to be "supported by substantial evidence when the record is viewed as a whole." [42] As originally created, the decision of the Board was to be final unless the Secretary on his own motion reversed or modified the Board's decision adversely to the provider. This provision is substantially modeled on the following language in § 557(b), 5 U.S.C., which provides:

> "* * * When the presiding employee makes an initial decision, that decision then becomes the decision of the agency without further proceedings unless there is an appeal to, *or review on motion of*, the agency within time provided by rule." (Italics added)

This provision of the Administrative Procedure Act, even if the 1972 amendment had not so provided, would have made the decision of the Board the final decision or the "decision of the [Secretary]" "unless there is * * * review on motion of" the Secretary, but, if "on his own motion" the Secretary reviews and reverses that decision of the Board, the appropriate decision for review judicially would of course have been that of the Secretary and the scope of review would have been governed by the clearly erroneous rule. The provider itself, however, had no right under the 1972 amendment to judicial review of the Board's decision *unless* the Secretary "on his own motion" had reversed or modified the Board's decision. In the event, but only in the event, the Secretary did reverse or modify the Board's decision, might there be judicial review of the Secretary's decision.

In 1974 Congress amended subsection (f) of § 1395oo by granting to the provider "the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification" of the Board's decision by the Secretary.[43] This amendment was intended, as the Congressional history reveals, to "permit judicial review of the Board's unmodified findings as well" as of the Secretary's reversals or modifications of the Board's decision.[44]

It is the appellant's position, supported by the *amicus*, that, as a consequence of the unique composition and power of the Board, its decision, certainly as to any factual findings, could only be reviewed by the Secretary for want of substantial evidence to support its decision. It does not contend that the 1972 amendment or the 1974 amendment explicitly so narrows the Secretary's scope of review as to deny to him the usual power of review exercisable by the agency head in administrative proceedings. It concedes that the amendments are silent on any specific intention to so

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[41] U.S. Code Cong. & Adm. News, 92nd Cong. 2d Sess. (1972), p. 5094.

[42] 1395oo(d), 42 U.S.C.

[43] § 1395oo(f)(1).

These provisions of both the 1972 and 1974 statutes are explained in U.S. Code Cong. & Adm. News, 92nd Cong., 2d Sess. (1972) at pp. 5094–5 and p. 5388 and in the same service 93rd Cong., 2d Sess. (1974) at pp. 5994–5996.

[44] See note 43.

limit the Secretary's scope of review. But it argues that this limitation is implicit in the language of the amendments fixing the Board's own method of decision. Thus, it says that the statements in the statute that the Board's decisions "shall be supported by substantial evidence when the record is viewed as a whole" [45] carries with it the necessary implication that, in reviewing the Board's factual findings, the Secretary's own scope of review is limited to a determination of whether the Board's decision is "supported by substantial, evidence when the record is viewed as a whole." Based on the assumption that this is the correct construction of the 1972 and 1974 amendments, the appellant asserts that the decision of the Board in this case, which turned, in its view, solely on the resolution of a factual issue, was supported by substantial evidence in the record and that the Secretary was accordingly precluded from reversing such decision.

It would seem that, even under the appellant's construction of the amendments, the Secretary would be entitled to reverse the decision of the Board if the latter's decision evidenced an egregious error in connection with a critical fact in the case on which it could be said the factual issue may well have been resolved or if, in its review of the evidence, the Board applied an improper legal standard. The decision of the Board in this case is open to fault on both grounds. The Board's decision was in error in its finding on a critical factual issue in the case. The lease granted the pharmacy-supplier by the hospital-provider was an important fact—in fact, it might have well been the decisive fact, so far as the Board was concerned—in the case. It was the intermediary's position that the lease was privately negotiated between the two parties without considering any competitive bids for such a lease from any other pharmacy. This fact was regarded as a critical point by the intermediary because it lent strong support to the intermediary's theory that the lease was a "sweetheart" contract. The Board, however, categorically found that "the aforesaid pharmacy lease was [not a noncompetitive contract but] one of three proposals submitted for approval to the Provider's contract committee'." The Secretary submits in his brief that this finding is clearly erroneous. The appellant does not contradict this assertion of the Government in its reply brief. We can, therefore, safely assume both on the basis of our own review of the record and on the undisputed statement of the Government that this finding of the Board on a critical factual issue was clearly erroneous.

Even more important is the Board's error in its own standard of review and in its ruling on burden of proof. The Board assumed that the intermediary had the burden of proving that the provider's claim for reimbursement was not allowable under the Regulation rather than that the provider had the burden of establishing that its claim for reimbursement was allowable under the applicable regulations. But not only did it thus improperly place the burden of proof on the intermediary [46] but also it held that, in order to sustain such burden, the intermediary had to prove

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[45] § 1395oo(d). 42 U.S.C.

[46] *See* Davis, *Administrative Law of the Seventies*, § 14.14 at pp. 345–6 (1976); *Stearns Elec. Paste Co. v. Environmental Protection Agency* (7th Cir. 1972) 461 F.2d 293, 305, notes 38 and 39; *Woodland Nursing Home Corp. v. Weinberger* (S.D. N.Y. 1976) 411 F. Supp. 501, 505.

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relatedness under the Regulation by "compelling or conclusive evidence." Thus, in finding for the appellant-provider, the Board based its decision on a finding that the intermediary had not presented compelling or conclusive evidence * * * that the Provider [was] related" to the pharmacy-supplier. If this standard for evaluating the evidence is erroneous as a matter of law, the error would clearly vitiate the Board's decision and the Secretary would have plain authority, even under the appellant's own construction of the amendments, to reverse the Board.[47] There is no reason to assume in administrative proceedings that the proponent of any fact must establish that fact by "conclusive" evidence rather than by the preponderance of evidence any more than the litigant is so required in any other type of proceeding. There are some unique types of cases, such as actions in fraud, where the courts have adopted the rule that the proof must be "compelling" but this proceeding does not fall within such rule. The Board obviously followed an incorrect standard of proof.

It must not be assumed from what has been said that we agree with the appellant's assumption with respect to the Secretary's scope of review. While the provisions of §1395oo, as amended, may not conform to the normal phraseology pattern in providing for administrative review,[48] we do not find that the mere fact that in this statute the Board, which is to hear the controversy initially, and is directed to make its decision on "substantial evidence," has placed a halter on the Secretary's usual scope of administrative review, in the absence of any suggestion in the legislative history, or in the express language of the amendments to support such a conclusion. The District Court aptly observed that in *Universal Camera Corp. v. Labor Bd.* (1951) 340 U.S. 474, 492, the Court found such a limitation on an agency's power of review would be "so drastic a departure from prior administrative practice that explicitness [in such a limitation on the Secretary's scope of review] would be required." The appellant would dismiss the relevancy of this statement to this proceeding because it was made in connection with proceedings before another agency. However, this statement of the Court was not a statement based on some peculiar feature of review under the National Labor Act; it related to "administrative practice" as followed generally. It was thus of general application and we see no reason for finding it irrelevant in this connection. As in *Universal Camera,* so here it would be "a drastic departure from prior administrative practice" to circumscribe the Secretary's scope of review as narrowly as appellant would have us do. In the absence of an explicit contrary statement in the amendments, we conclude that the Secretary's right of review was not limited to a review merely for substantial evidence.

It is argued, however, that the Secretary has himself found that his scope of review is restricted to determining whether the decision of the Board is supported by substantial evidence and cites as evidence the Secretary's decision in *Dec. of Social Security Commn'r* (July 13, 1976), (CCH Medicare and Medicaid Guide 27,909). We do not find in that decision any reference to the scope of the Secretary's review of the Board's decisions.

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[47] Davis, *Administrative Law of the Seventies,* § 16.01, p. 397 (1976).

[48] *Cf., however,* § 557(b), 5 U.S.C., discussed *supra.*

The Commissioner merely said that: "[T]he record supports the Board's decision and no prejudicial error has been found." That sentence is manifestly not a holding by the Secretary that his scope of review is as urged by the appellant. We find no more persuasive the suggestion as advanced by the *amicus* that because, in a proposed bill, now pending in Congress, final decision-making authority is granted the Board in making certain determinations in proceedings authorized in that bill, it must be assumed that Congress intended, when it enacted the 1972 and 1974 amendments, dealing as those amendments did with entirely different determinations by the Board, the same scope of review was to apply as was provided in the new bill for other determinations in other types of proceedings made by the Board, after the Board had been enlarged for the purpose of making such new determinations. We find no basis in either of these suggestions for restricting the Secretary's scope of review to review for substantial evidence.

Finally, the appellant urges that the decision of the Secretary, even if reviewable under the clear error rule, was clearly erroneous. The District Court carefully reviewed the Secretary's decision and concluded it was not clearly erroneous and was supported by substantial evidence in the record. We find no error in this ruling of the District Court.

The decision of the District Court is accordingly

AFFIRMED.

SECTION 1814 and SECTION 1861 (v)(1)(A) (42 U.S.C. 1395f and 1395x(v)(1)(A)—HEALTH INSURANCE BENEFITS—PROVIDER REIMBURSEMENT—COST OF EDUCATIONAL ACTIVITIES AND ALLOCATION OF NET COST OF EDUCATIONAL ACTIVITIES TO ALL DEPARTMENTS OF PROVIDER

42 CFR 405.421 et seq. HCFAR 79–61c

Mercy Hospital and Medical Center San Diego v. Califano, USDC, Calif., CIV. No. 76–148T (12/13/77).

A hospital participating in the Medicare program operates an outpatient clinic in which patient care services are furnished, at least in part, by students in approved internship and residency programs. Because the hospital must operate the clinic to maintain the accreditation of its training programs, it considers the clinic itself to be an educational activity and thus the clinic's net operating deficit to be a reimbursable educational cost. In completing its Medicare cost report, the hospital allocated the net operating deficit of the clinic to its inpatient service departments on the theory that educational costs are reimbursed by Medicare only under Part A of the program. *Held,* the net operating deficit of a department in which patient care services are furnished may not be considered a cost of approved educational activites merely because the services are furnished by interns and residents in approved educational programs; and *further held,* a hospital's net cost of approved educational activities, as determined under 42 CFR 405.421, must be allocated among all departments of the hospital served by interns and residents in order to accurately reflect the amount of net educational cost properly attributable to each department. In this way each department's costs can then be apportioned between Medicare and non-Medicare patients, thus insuring that the Medicare program does not make payment for the costs of services provided non-Medicare patients.

TURRENTINE, District Judge

This case came on for hearing on December 5, 1977. The plaintiff and defendant filed cross motions for summary judgment. The gravamen of the complaint is the refusal of the Provider Reimbursement Review Board ("PRRB") to change the adjustment made by the Blue Cross Plan in the claim submitted by the plaintiff. In general, the Blue Cross Plan rejected the plaintiff's accounting theory of considering the deficit of the outpatient clinic as an "educational cost" reimbursable by Medicare funds.

The plaintiff, Mercy Hospital and Medical Center, is a general, short-term, nonprofit institution with approximately five hundred beds. Although the hospital is not solely devoted to teaching, it does provide educational opportunities for interns and residents. In order to maintain its teaching accreditation, the plaintiff has been required to maintain an outpatient clinic ("Clinic") for ambulatory care experience.

The plaintiff has maintained the Clinic since 1963. Screening procedures are utilized by the plaintiff to admit only those patients to the Clinic that have illnesses of teaching value. Medicare beneficiaries compose 3.5 percent of the population of the Clinic; however, approximately 40 percent of the hospital's inpatients are Medicare beneficiaries.

The plaintiff and the defendant stipulate to the facts discussed in the PRRB decision; however, the parties disagree on the amount of Medicare reimbursement to cover the deficit generated by the Clinic.

* * * * *

The court agrees with the decision of the PRRB to deny reimbursement to the plaintiff for the deficit of the Clinic. Medicare should pay its proper proportion of educational costs, but those costs should be based on the number of Medicare patients in the Clinic, not the number of Medicare inpatients in the hospital. Moreover, in considering the proper method of reimbursement, the court finds that the care and treatment accorded to the patients in the Clinic should be considered as patient care and not as an educational cost. If such care is defined as an educational cost, then Medicare would be used to fund net deficits of hospitals that operate primarily as teaching hospitals.

If the court were to agree with the plaintiff's argument that Medicare should pay for the deficit of the Clinic in a proportion greater than the number of Medicare patients treated in the Clinic, then the Medicare program would be paying for the treatment of non-Medicare beneficiaries. Such payment would violate Congressional intent as stated in 42 U.S.C. § 1395x(v)(1)(A).

Medicare and educational accreditation are separate programs with separate goals. Although the educational effort of the plaintiff may be hampered by the court's decision, Medicare funding is not available for the treatment of non-Medicare beneficiaries.

Accordingly,

IT IS ORDERED that the defendant's motion for summary judgment be and the same is hereby granted.

DATED: December 13, 1977

I. B. Professional Standards Review Organization Program

SECTION 1151 et. seq. (42 U.S.C. 1320c–1320c–19)—PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS—PSRO DESIGNATIONS—AUTHORITY OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE TO IMPLEMENT THE FEDERAL "PROFESSIONAL STANDARDS REVIEW" LAW

42 CFR PART 460 et. seq. HCFAR 79–62c

Association of American Physicians and Surgeons v. [*Casper W.*] *Weinberger, 395 F. Supp. 125 ND Illinois (5/8/75)*

> The plaintiffs sought to enjoin the Secretary of Health, Education, and Welfare from implementing the Federal "Professional Standards Review" Law (42 U.S.C. Section 1320c through Section 1320c–19) and to declare the law unconstitutional on its face on the ground that it violates rights guaranteed the plaintiffs and their patients by the First, Fourth, Fifth, and Ninth Amendments to the United States Constitution.

The United States District Court granted the Secretary's motion to dismiss the case for failure to state a claim upon which relief can be granted or, in the alternative, for summary judgment. In its decision the Court *held* that:

> (1) The statute does not act upon the plaintiffs in such a mandatory fashion as to amount to an unconstitutional interference with plaintiffs' right to practice their profession;
> (2) The system of norms to be established under the statutory scheme will not unconstitutionally interfere with the physician-patient relationship;
> (3) The reporting procedures in the challenged legislation do not unconstitutionally interfere with plaintiffs' right to privacy, but are reasonable in scope in that they contain provisions designed to assure confidentiality;
> (4) The language of the challenged legislation is not impermissibly vague or uncertain;
> (5) The possibility of exposure to civil liability sometimes in the future as a result of complying with the statutory norms is not a real and immediate threat of injury sufficient to sharpen the issues and place them within reach of adjudication on constitutional grounds;
> (6) Plaintiffs' contention that the statute creates presumptions inconsistent with plaintiffs' licensure in violation of the Fifth Amendment is without merit;
> (7) Plaintiffs' allegation that these private organizations (Professional Standards Review Organizations) will be biased in reviewing Medicare and Medicaid cases is totally without merit. Moreover, the use of private agencies to perform Government functions is constitutionally permissable.

The Court further *held* that Congress, in enacting the Professional Standards Review legislation as a vehicle to better control expenditures in connection with the Medicare and Medicaid programs, chose means to attain these economic goals that are not arbitrary and totally lacking in rationality, but that preserve a balance between the rights of physicians, other providers of health care services in the Medicare and Medicaid programs, and those of the Government in providing and maintaining medical care to those most in need of it.

Plaintiffs bring this action seeking to enjoin the Secretary of Health, Education and Welfare from implementing the Federal "Professional Standards Review" Law (42 U.S.C. Section 1320c through Section 1320c–19) and to declare said law unconstitutional on its face on the ground that it violates rights guaranteed the plaintiff physicians and their patients by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution. Jurisdiction is invoked pursuant to Section 1331 of Tilte 28 of the United States Code, and a three-judge court has been convened in accordance with the provisions of 28 U.S.C. Sections 2282 and 2284. This cause now comes before the Court on defendant's motion for summary judgment.

Since there are no factual issues presented to the Court, only issues of law relating to the facial invalidity of the challenged legislation, defendant has framed his motion as one for summary judgment. However, defendant has also indicated, at the hearing on said motion, that his motion could properly be treated as a motion to dismiss the Complaint for failure to state a claim upon which relief can be granted.

In order to more fully comprehend the constitutional objections to the challenged legislation it is first necessary to examine the basic statutory framework of the "Professional Standards Review" Law as set out in Section 1320c through 1320c–19 of Title 42 of the United States Code. Following this examination the Court will consider the various constitutional attacks on the legislation.

I

The Nature of the "Professional Standards Review" Legislation

With the Federal Government assuming the position as the largest health insurer in the United States through the enactment of the Medicare and Medicaid programs (42 U.S.C. Sections 1395–1395pp and 42 U.S.C. Sections 1396–1396i respectively), Congress has become increasingly concerned with the tremendous costs incurred in implementing such programs.

In examining the rising cost of these programs the Senate Committee on Finance noted:

> . . . The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on medicare and medicaid. Witnesses testified that a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact the committee is most concerned about the effect of overutilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care. Sen. R. No. 92–1230, 92d Cong., 2d Sess. 254 (1972).

It was directed at this problem of overutilization that Congress enacted Section 249F of Title II of the 1972 Amendments to the Social Security Act, 42 U.S.C. Sections 1320c—1320c–19, entitled "Professional Standards Review." The Congressional intent behind enactment of this legislation is set forth in Section 1320c of Title 42 of the United States Code which provides that payment for services performed under medicare and medicaid will be made:

> (1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and
> (2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion. 42 U.S.C. Sec. 1320c.

In furtherance of this objective Congress has established, under the Act, a number of new organizations and some new limitations of liability.

Under the challenged legislation the Secretary of Health, Education and Welfare shall establish throughout the United States "appropriate areas" with respect to which "Professional Standards Review Organizations" ((hereinafter referred to as "PSRO's") may be designated. Upon designation of an appropriate area, the Secretary must then enter into an agreement with a "qualified organization" which becomes the PSRO for that area. 42 U.S.C. Section 1320c–1(a).

To be qualified under the Act an organization must be a non-profit professional association composed of licensed doctors practicing in the appropriate area, whose membership includes a substantial proportion of all such doctors in the area. The statute sets forth additional requirements for qualification including a finding by the Secretary of Health, Education and Welfare that the organization is one that is willing and able to perform the functions of a PSRO. 42 U.S.C. Section 1320c–1(b)(2).

After designation of a "qualified organization" as a PSRO for an appropriate area, each PSRO must assume

> . . . responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under this chapter for the purpose of determining whether—
> (A) such services and items are or were medically necessary;
> (B) the quality of such services meets professionally recognized standards of health care; and
> (C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type. 42 U.S.C. Section 1320c–4(a)(1).

In order to assure that services provided under medicare and medicaid are medically necessary and of professional quality, the statute requires

practitioners and providers of health care services to furnish such evidence as may reasonably be requested by a PSRO. 42 U.S.C. Section 1320c–9(a)(2).

If the Secretary agrees with the report and recommendation of a PSRO that a particular practitioner or provider of services has either (1) failed, in a substantial number of cases to comply with any of the obligations set forth in the statute or (2) grossly and flagrantly has violated any such obligation in one or more instances and that sanctions are warranted, that practitioner or provider may be excluded from participation in the medicare and medicaid programs. 42 U.S.C. Section 1320c–9(b)(1). The legislation provides for notice and hearing of such determinations. 42 U.S.C. Section 1320c–9(b)(4).

Each PSRO will have the authority to determine whether any elective admission to a hospital or other health care facility, or any other health care service which will consist of extended or costly courses of treatment is medically necessary or could be provided for in a more economical manner. 42 U.S.C. Section 1320c–4(a)(2). If a PSRO determines that such services are not medically necessary or that they could be performed in a more economical manner, no federal funds may be used as payment for such services. 42 U.S.C. Section 1320c–7. However, the Act provides that only a licensed physician can make a final determination as to the professional conduct of any other physician. 42 U.S.C. Section 1320c–4(c).

The legislation also requires a PSRO to give notice of any determination denying a request for approval of health care service or any determination that a practitioner or provider has violated any obligation imposed by the statute. 42 U.S.C. Section 1320c–10. In determining whether the services rendered are consistent with the criteria set forth in Section 1320c–4(a)(1), PSRO's are required to maintain profiles on each practitioner and provider of health care services. A coding method is employed in order to provide maximum confidentiality and objective evaluation. 42 U.S.C. Section 1320c–4(a)(4).

To aid each PSRO in its evaluation and review process certain professional norms of care, diagnosis and treatment are established which shall include the types and extent of health care services considered within the range of appropriate diagnosis and treatment for a particular illness or condition and the most economical type of health care facility considered medically appropriate. 42 U.S.C. Section 1320c–5(b). In order to coordinate the activities of various PSRO's and to assist the Secretary in evaluating the performance of each PSRO, a number of statewide Professional Standards Review Councils and a National Professional Standards Review Council are to be established by the Secretary. 42 U.S.C. Section 1320c–11(a) and 42 U.S.C. Section 1320c–12(a).

Finally, the challenged legislation provides certain limitations of liability including a section that provides that:

> No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of

care and treatment applied by a Professional Standards Review Organization . . . operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

(1) he takes such action (in the case of a health care practitioner) in the exercise of his profession as a doctor of medicine or osteopathy (or in the case of a provider of health care services) in the exercise of his functions as a provider of health care services, and

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment. 42 U.S.C. Section 1320c–16(c).

In summary, the Court notes that the "Professional Standards Review" Law is a massive piece of Legislation which represents, for the first time, a nationwide program of medical utilization review.

II

Constitutionality of the "Professional Standards Review" Legislation

Given these pertinent statutory sections as background, plaintiffs seek a declaratory judgment that the legislation is unconstitutional on its face and a permanent injunction restraining the defendant from implementing the legislation. Plaintiffs' challenges to the constitutionality of the legislation have their origin in the First, Fourth, Fifth and Ninth Amendments to the United States Constitution. The basic constitutional challenges to the legislation are:

(A) that the legislation unconstitutionally deprives plaintiffs of their right to practice their profession in violation of the Fifth Amendment;

(B) that the legislation unconstitutionally interferes with the physician-patient relationship in violation of the Fifth Amendment;

(C) that the legislation unconstitutionally invades the privacy of the plaintiffs and their patients in violation of the First, Fourth, Fifth and Ninth Amendments;

(D) that the legislation is unconstitutionally vague and uncertain in violation of the Fifth Amendment;

(E) that Congress unconstitutionally exercised its power in imposing limitations of liability under the legislation in violation of the Fifth Amendment;

(F) that the legislation unconstitutionally creates presumptions inconsistent with plaintiffs' licensure in violation of the Fifth Amendment; and

(G) that the legislation unconstitutionally empowers biased private organizations to exercise quasi-judicial authority over plaintiffs in violation of the Fifth Amendment.

Since the Act has yet to be applied, these constitutional challenges are addressed to the constitutionality of the Act on its face. Due to the full panoply of constitutional rights that is alleged to be infringed by numerous provisions of the "Professional Standards Review" legislation and due to the fact that the instant case represents one of the first constitutional challenges to this new legislation, it becomes necessary for the Court to consider each of these contentions separately and in some detail.

A. Plaintiffs' Right to Practice Their Profession

Plaintiffs argue that the challenged legislation violates their constitutional rights as guaranteed by the Fifth Amendment in that it is arbitrary and overbroad and interferes with the plaintiffs' right to practice their profession.

Similar arguments were raised in the case of *Rasulis v. Weinberger*, 502 F. 2d 1006 (7th Cir. 1974). The statutory regulation under attack in *Rasulis* established professional standards which physical therapists must meet in order to qualify for reimbursement under the Medicare Program. 20 CFR Sec. 405.1101(q).

In rejecting plaintiffs' argument that the regulation was arbitrary and violative of the Due Process Clause of the Fifth Amendment, the Court of Appeals noted:

> The Due Process Clause prohibits only those classifications within a Federal social welfare program that are patently arbitrary and totally lacking in rational justification. *Fleming v. Nestor*, 363 U.S. 603, 611 (1960). Accord, *Gruenwald v. Gardner*, 390 F. 2d 591, 592 (2nd Cir. 1968), *cert. denied*, 393 U.S. 982 (1968); *Price v. Flemming*, 280 F. 2d 956 (3rd Cir. 1960), *cert. denied*, 365 U.S. 817 (1961). And ". . . regulation which is reasonable in relation to its subject and is adopted in the interests of the community is due process." *West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 391 (1937). See generally *Dandridge v. Williams*, 397 U.S. 471, 485 (1970); *McGowan v. Maryland*, 366 U.S. 420, 425–26 (1961); *Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483, 489 (1955). 502 F. 2d at 1009.

Thus, the Court concluded:

> The challenged legislation does not stray outside the boundaries of permissible regulation. It merely provides standards for the dispensation of Federal funds. The economic incentive of participation in the Medicare Program does not constitute coercion or control. See Cardozo J. for the Court in *Steward Machine Co. v. Davis*, 301 U.S. 548, 589–90 (1937) 502 F. 2d at 1010.

Although the "Professional Standards Review" legislation represents a more comprehensive regulatory scheme than that encountered in *Rasulis*, the constitutional principles to be applied are the same in each. In order to avoid overutilization of health care services and to achieve more effective control over the costs of those services, Congress has enacted the "Professional Standards Review" legislation. The legislation does set forth certain professional standards which must be met in furtherance of this statutory purpose. The statute, however, does not bar physicians from practicing their profession but only "provides standards for the dispensation of Federal funds." Considering the purpose behind this statutory scheme and the requirements set forth in the statute to achieve this purpose, this Court finds that the challenged legislation is not so 'patently arbitrary and totally lacking in rational justification" as to be violative of the Due Process Clause of the Fifth Amendment.

In support of their argument that the challenged legislation is arbitrary in violation of the Fifth Amendment, the defendants have mainly relied on three liens of cases: (1) where the legislation was attacked on the ground that it established an arbitrary or invidious discrimination; (2) where legislation was held to have lacked critical elements of procedural due process; and (3) where certain legislation was found to bear no reasonable relationship to any legitimate governmental end.

Plaintiffs have presented a number of cases involving legislation challenged as establishing arbitrary or invidious discrimination. *Memorial Hospital v. Maricopa County*, 94 S. Ct. 1076 (1974); *United States Department of Agriculture v. Moreno*, 413 U.S. 528 (1973); and *Shapiro v. Thompson*, 394 U.S. 618 (1969). However, the instant complaint lacks any specifications of how the "Professional Standards Review" Law creates any arbitrary or invidious discrimination.

In addition, these cases offered by plaintiffs can easily be distinguished from the case at bar. The case of *Memorial Hospital v. Maricopa County, supra,* struck down a one-year state residency requirement for county financed medical care on the ground that it created an invidious distinction between classes of citizens. In *United States Department of Agriculture v. Moreno. supra,* the Court struck down a statute limiting eligibility for food stamps to households consisting only of related individuals because such a limitation constituted a classification "wholly without any rational basis." 413 U.S. at 538.

Similarly, in *Shapiro v. Thompson, supra,* the Supreme Court invalidated a one-year residency requirement for becoming eligible for Medicare on the ground that this legislative scheme established invidious discrimination. Unlike the statutory schemes invalidated as creating an arbitrary or invidious discrimination in *Maricopa, Moreno* and *Shapiro,* the challenged legislation in the instant suit does not establish any arbitrary or invidious discrimination in violation of the Fifth Amendment. Thus, the Court finds that these cases are not supportive of plaintiffs' position that the "Professional Standards Review" Law is arbitrary in violation of the Fifth Amendment.

Plaintiffs have further argued that this legislation lacks critical elements of procedural due process. Such an argument is not well-founded. Section 1320c–9(b)(4) of Title 42 of the United States Code provides that no physician can be barred from participation in the Medicare or Medicaid programs without notice and a hearing. Further, the legislation allows a hearing and review by the Secretary of all PSRO determinations denying payment for services where the amount in controversy is $100.00 or more; and if that amount is $1,000.00 or more, the aggrieved party is entitled to judicial review of an adverse determination by the Secretary. 42 U.S.C. Sec. 1320c–8. Finally, the challenged legislation provides that a PSRO must give notice to any practitioner or provider of any determination (1) denying any request for approval of health care service or (2) that such practitioner or provider has violated any obligation imposed upon him by the legislation. 42 U.S.C. Sec. 1320c–10.

These statutory provisions satisfy the demands of procedural due process by apprising the practitioner or provider of any adverse determination

and by affording him an opportunity to be heard either by the Secretary or through the avenue of judicial review. Such safeguards are consonant with the concept of procedural due process as embodied in the Fifth Amendment.

Finally, plaintiffs argue that the legislation is arbitrary because it bears no reasonable relationship to any end within the competency of government. As the plaintiffs themselves have noted, "the primary purpose of the Act is to control the rapidly rising costs of governmental health care delivery systems." (Plaintiffs' Memorandum in Opposition at page 23). Such a statutory purpose can hardly be considered to be one outside the competency of the Federal Government, particularly in light of the already extensive government regulation in the health care field.

Plaintiffs have also attacked the Act on the ground that it is unconstitutionally overbroad citing the case of *City of Carmel-by-the-Sea v. Young*, 2 Cal. 2d 259, 466 P.2d 225, 85 Cal. Rptr. 1 (1970). In *City of Carmel* a state statute requiring all public officers and candidates to disclose not only their own financial investments but also those of their families was struck down as being overbroad.

However, the United States Supreme Court in *Dandridge v. Williams*, 397 U.S. 471 (1970), has indicated that the overbreadth doctrine has little application to social welfare legislation.

> For this Court to approve the invalidation of state economic or social regulation as "overreaching" would be far too reminiscent of an era when the Court thought the Fourteenth Amendment gave it power to strike down state laws "because they may be unwise, improvident, or out of harmony with a particular school of thought." *Williamson v. Lee Optical Co.*, 348 U.S. 483, 488. That era long ago passed into history, *Ferguson v. Skrupa*, 372 U.S. 726. *Dandridge v. Williams*, 397 U.S. at 484–85.

Accordingly, the Court finds plaintiffs' argument that the instant legislation is unconstitutionally overbroad to be wholly without merit.

Finally, plaintiffs argue that the challenged legislation violates the Fifth Amendment in that it unconstitutionally interferes with their right to practice. In support of this argument plaintiffs place heavy reliance on a series of decisions striking down various criminal abortion statutes. *Doe v. Bolton*, 410 U.S. 179 (1973); *Roe v. Wade*, 410 U.S. 113 (1973); *Poe v. Menghini*, 339 F Supp. 986 (D. Kan. 1972) (three judge court).

In *Doe v. Bolton, supra*, and *Roe v. Wade, supra*, the Supreme Court struck down the Georgia and Texas criminal abortion statutes respectively. In *Doe v. Bolton, Roe v. Wade* and *Poe v. Menghini*, the challenged statutes provided criminal penalties for performing abortions except under specified circumstances.

The "Professional Standards Review" Law does not prohibit a physician from performing any surgical operations he deems necessary in the exercise of his professional skill and judgment. It merely provides that if a practitioner wishes to be compensated for his services by the Federal Government, he is required to comply with certain guidelines and procedures enumerated in the statute.

These statutory requirements do not act in the same mandatory fashion upon the plaintiffs as did the criminal abortion statutes invalidated in

Doe v. Bolton, Roe v. Wade. Rather the legislation sets forth certain review procedures to be complied with for any practitioner wishing to participate in the program and to be paid by the Federal Government.

Underlying the constitutionality of the challenged legislation is the basic premise that each individual physician and practitioner has the ability to choose whether or not to participate in the program. It is true that there will exist economic incentive or inducement to participate in the program. However, such inducement is not tantamount to coercion or duress.

In *Steward Machine Co. v. Davis,* 301 U.S. 548 (1937), the constitutionality of a social security tax on employers was attacked on the ground that it constituted coercion on states to enact state welfare programs by allowing a credit against the tax for taxes paid to state welfare plans. In rejecting the contention that the legislation unconstitutionally coerced states into enacting welfare programs. Justice Cardozo, speaking for the Court stated:

> But to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties. The outcome of such a doctrine is the acceptance of a philosophical determination by which choice becomes impossible. Till now the law has been guided by a robust common sense which assumes the freedom of will as a working hypothesis in the solution of its problems. [301 U.S. at 589–90]

In applying the "common sense" approach of Justice Cardozo to the question of whether the instant legislation is coercive in nature, the Court finds that the statute does not act upon the plaintiffs in such a mandatory fashion as to amount to an unconstitutional interference with plaintiffs' right to practice.

B. Interference with the Pysician—Patient Relationship

Plaintiffs argue that the challenged legislation unconstitutionally interferes with the doctor-patient relationship. Specifically, plaintiffs allege that the system of norms of care, diagnosis and treatment to be established under the statutory scheme, "will have a chilling effect on the case-by-case practice of medicine and innovative progress in medical practice, to the ultimate detriment of plaintiffs and their patients."

Initially the Court notes that plaintiffs' argument appears premature in that the particular norms under attack have yet to be established. The argument is essentially based on the premise that such norms of diagnosis, treatment and care are inherently incapable of reduction to specific language.

The Court is cognizant of the difficulties encountered in drafting norms with sufficient specificity to afford meaningful notice to the practitioner and with adequate flexibility to reach a multitude of individual medical cases. However, the task is not an impossible one. Although the challenged legislation establishes, for the first time, a unified national program of medical utilization review, norms have been employed in private medical utilization review programs for a number of years. See *R. B. Schumer,*

Hospital Utilization Review and Medicare: A Survey at pages 8–9 (Government Printing Office, Washington, D.C. 1973).

The statute specifically provides that the norms must include:

> . . . the type and extent of the health care service which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care . . . 42 U.S.C. Sec. 1320c–5(b)(1).

Further, the purpose behind the implementation of these norms was clearly set forth in the legislative history of the statute.

> Neither should the use of norms as checkpoints nor any other activity of the PSRO be used to stifle innovative medical practice or procedures. The intent is not conformism in medical practice—the objective is reasonableness. Sen. R. No. 92—1230 at 263.

Given the legislative standard of reasonableness and the statutory flexibility to take into account various methods of treatment, the Court finds no merit to plantiffs' argument that the system of norms to be established under the statutory scheme will unconstitutionally interfere with the physician-patient relationship.

C. The Right of Privacy of Plaintiffs and Their Patients

Plaintiffs argue that the statutory sections requiring plantiff to furnish information concerning their patients violate the constitutional right of privacy of plaintiffs and their patients as guaranteed by the First, Fourth, Fifth and Ninth Amendments.

The purpose of the information sought from plaintiffs is to enable the Professional Standards Review Organization to assemble patient profiles upon which they can determine whether the services performed under the Medicare and Medicaid Programs were medically necessary and done in an economical manner. The legislation also provides that reporting procedures should utilize to the greatest extent possible "methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part." 42 U.S.C., Section 1320c–4.

Further, the statute provides in pertinent part that:

> (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases and under such circumstances as the Secretary shall by regu-

lations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care.

(b) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000 and imprisoned for not more than six months, or both, together with the costs of prosecution. 42 U.S.C., Section 1320c–15.

These statutory provisions make it clear that the maximum confidentiality is to be maintained concerning the information furnished by the physicians to the Professional Standards Review Organizations.

In *California Bankers Association v. Shultz*, 416 U.S. 21 (1974), the Supreme Court considered whether various provisions of the Bank Secrecy Act of 1970 and regulations promulgated thereunder amounted to an unconstitutional invasion of privacy. Under the authority of the Act, the Secretary of the Treasury promulgated regulations requiring banks to report domestic currency transactions of $10,000 or more. In upholding the constitutionality of the regulation. the Court stated:

> The regulations do not impose unreasonable reporting requirements on the banks. The regulations require the reporting of information with respect to abnormally large transactions in currency, much of which information the bank as a party to the transaction already possesses or would acquire in its own interest. To the extent that the regulations in connection with such transactions require the bank to obtain information from a customer simply because the Government wants it, the information is sufficiently described and limited in nature, and sufficiently related to a tenable congressional determination as to improper use of transactions of that type in interstate commerce, so as to withstand the Fourth Amendment challenge made by the bank plaintiffs. "(T)he inquiry is within the authority of the agency, the demand is not too indefinite and the information sought is reasonably relevant. 'The gist of the protection is in the requirement, expressed in terms, that the disclosure sought shall not be unreasonable.'" *United States v. Morton Salt Co.*, supra, at 652–653; see *Oklahoma Press Publishing Co. v. Walling*, 327 U.S. 186, 208 (1946).

The challenged legislation in the instant suit seeks information for a legitimate governmental purpose. The manner in which the information is gathered and maintained is reasonable in light of the above-quoted statutory provisions that are designed to assure proper confidentiality. The Court finds that these provisions do not infringe on the constitutionally protected right of privacy of plaintiffs.

In support of their argument that the legislation violates their right of privacy, plaintiffs place heavy emphasis on the case of *Roe v. Ingraham*, 480 F.2d 102 (2d Cir. 1973). In *Roe* the Second Circuit Court of Appeals considered the constitutionality of a New York law which required that certain drugs be prescribed only on a state prescription form, two copies of which had to be filed with the State Department of Health. In reversing the District Court's dismissal of the suit, the Court of Appeals significantly noted:

> If it were clear that the State had taken or proposed to take effective steps, by regulation or otherwise, to limit access to the patients' names on

the prescription forms as rigidly as is consistent with accomplishment of the asserted statutory purpose, the grounds for constitutional attack might disappear. 480 F.2d at 109.

The case of *Roe v. Ingraham, supra,* can be distinguished from this suit. Unlike the statute under constitutional attack there, the "Professional Standards Review" Law does limit access to the information under penalty of criminal sanctions. After reviewing a number of cases dealing with the right of privacy, the Supreme Court in *Roe v. Wade, supra,* noted:

> Although the results are divided, most of these courts have agreed that the right of privacy, however based, is broad enough to cover the abortion decision; that the right, nonetheless, is not absolute and is subject to some limitations; and that at some point the state interests as to protection of health, medical standards, and prenatal life, become dominant. We agree with this approach. [410 U.S. at 155]

The "Professional Standards Review" legislation contains provisions that properly balance the plaintiffs' right of privacy with the Government's interest in maintaining proper health care in an economical manner.

Finally, in regard to plaintiffs' contentions concerning their right to privacy, the Court notes that plaintiffs have argued that the legislation violates the constitutional right of privacy of their patients. It is not at all clear that plaintiffs have the requisite standing in this case to assert the constitutional rights of their patients.

In *California Bankers Association v. Schultz,* 416 U.S. 21 (1974), the Supreme Court considered whether a private bank had standing to assert the right of their depositors. There the Court noted:

> It is true that in a limited class of cases this Court has permitted a party who suffered injury as a result of the operation of a law to assert his right even though the sanction of the law was borne by another, *Pierce v. Society of Sisters,* 268 U.S. 510 (1925), and conversly, the Court has allowed a party upon whom the sanction falls to rely on the wrong done to a third party in obtaining relief, *Barrows v. Jackson,* 346 U.S. 249 (1953); *Eisenstadt v. Baird,* 405 U.S. 438 (1972). Whether the bank might in other circumstances rely on an injury to its depositors or whether, instead, this case is governed by the general rule that one has standing only to vindicate his own rights, e.g., *Moose Lodge v. Irvis,* 407 U.S. 163, 166 (1972), need not now be decided, since, in any event, the claim is premature. 416 U.S. at 51.

Under the circumstances of this case, the claim of the plaintiffs on behalf of their patients is similarly premature. This suit attacks the constitutionality of the legislation on its face, and thus far there is no showing that a real and immediate injury or threat of injury exists to particular patients of these plaintiffs.

As the Supreme Court stated in *California Bankers Association v. Schultz, supra:*

> Plaintiffs in the Federal courts "must allege some threatened or actual injury resulting from the putatively illegal action before a Federal court may assume jurisdiction." *Linda R.S. v. Richard D.,* 410 U.S. 614, 617

(1973). There must be a "personal stake in the outcome" such as to "assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions." *Baker v. Carr*, 369 U.S. 186, 204 (1962) . . . Abstract injury is not enough. It must be alleged that the plaintiff "has sustained or is immediately in danger of sustaining some direct injury as a result of the challenged statute or official conduct." *Massachusetts v. Mellon*, 262 U.S. 447, 488 (1923). The injury or threat of injury must be both "real and immediate," not "conjectural" or "hypothetical." *Golden v. Zwickler*, 394 U.S. 103, 109–110 (1969); *Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273 (1941); *United Public Workers v. Mitchell*, 330 U.S. 75, 89–91 (1947); *O'Shea v. Littleton*, 414 U.S. 488, 493–494 (1974). 416 U.S. 21, 68–69.

In summary, the Court finds that the reporting procedures in the challenged legislation do not unconstitutionally interfere with plaintiffs' right to privacy. These procedures are reasonable in scope in that they contain provisions designed to assure confidentiality. Like the reporting procedures upheld in *California Bankers*, through these provisions "Congress is simply imposing a condition on the spending of public funds." 416 U.S. at 50.

D. Vagueness

Plaintiffs have argued that numerous words and phrases contained in this lengthy statute are so vague and uncertain "that plaintiffs must necessarily guess at their meaning" and that this lack of specificity is contrary to the requirements of the Fifth Amendment. In support of this position plaintiffs have cited numerous decisions involving criminal statutes invalidated under the vagueness doctrine.

Initially, the Court notes that much of plaintiffs' argument appears premature because of the absence of any application of these provisions. Nevertheless, the Court will consider plaintiffs' constitutional objections as they relate to the vagueness and uncertainty of the legislation on its face.

The test in determining whether or not a statute is unconstitutionally vague is whether men of common intelligence must necessarily guess at its meaning. Due to the particular application of this statute to physicians and other practitioners, the Court must also consider whether members of the medical profession must necessarily guess at the meaning of phrases set forth in the statute, such as "medically necessary," "professionally recognized health care standards," and "proper care."

Although the Court recognizes that these phrases are not highly specific, the Court believes that the language of the challenged legislation is not impermissibly vague or uncertain. As the Supreme Court stated in *United States v. Petrillo*, 326 U.S. 1, 7–8 (1947):

> . . . the Constitution does not require impossible standards. The language here challenged conveys sufficiently definite warning as to the proscribed conduct when measured by common understanding and practices. The Constitution requires no more.

Plaintiffs' reliance on numerous decisions invalidating various criminal statutes on the grounds of vagueness is misplaced. The present statutory

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scheme does not impose criminal sanctions. Nor does it provide for severance from the medical profession for non-compliance. See s.g., *Hewitt v. Board of Medical Examiners*, 148 Cal. 590, 84 P. 39 (1906). Rather the instant legislation only sets forth conditions for being compensated by Federal funds under the Medicare and Medicaid Programs. As was stated earlier, Congress faced a difficult task in drafting this statute with sufficient specificity to give the physicians, practitioners and providers of health care service adequate notice of the new requirements of the law and at the same time to maintain enough flexibility to cover a variety of medical cases. In accomplishing this task Congress did not stray beyond the permissible boundaries of the Constitution.

E. Constitutionality of the Limitations of Liability

The challenged legislation establishes certain limitations as provided, *supra,* in Section 1320c–16(c) of Title 42 of the United States Code. Plaintiffs contend that Congress lacks authority to grant legal immunity against common law tort liability; and if the immunity provisions of the challenged legislation are enforceable, the legislation imposes duties and obligations on plaintiffs which may unconstitutionally expose them to civil liability.

The Court does not now reach the merits of these claims because the plaintiffs lack the requisite standing to challenge the constitutionality of these limitations of liability. The proper party to raise such objections would be the beneficiaries or recipients under the Medicare and Medicaid Programs.

Further, plaintiffs' allegation that they "will be exposed to a serious risk of civil liability as a result of complying with the law" does not amount to a real and immediate threat of injury which would confer standing on these plaintiffs at this time.

The norms which are to be established and which the plaintiffs must comply with are, by definition, typical medical practices within the region where the physician practices. If a physician does not follow such typical procedures, he might be held liable for malpractice under state common law. The risk of civil liability arises from common law standards of negligence, not from the statute.

Thus, the possibility of exposure to civil liability sometime *in futuro* as a result of complying with these statutory norms does not amount to that type of real and immediate threat of injury which is necessary to sharpen the issues and place them in proper posture for adjudication. See *Baker v. Carr,* 369 U.S. 186, 204 (1962). There being no actual case or controversy at this time, the Court does not now reach the issue of the constitutionality of the limitations of liability established by the "Professional Standards Review" Law.

F. Presumptions Inconsistent with Plaintiffs' Licensure

Plaintiffs contend that the medical license carries certain presumptions of competence, good moral character, and regularity of motive and conduct, and that inconsistent presumptions are created by the statutory requirement that plaintiffs must provide evidence of their performance of services. In support of this position plaintiffs rely on language in the decision of *Doe v. Bolton, supra,* which struk down the two doctor concurrence requirement in the Georgia criminal abortion statute because such a requirement had "no rational connection with a patient's needs and unduly infringes on the physician's right to practice." 410 U.S. at 199.

The case of *Doe v. Bolton* is inapposite, however, it involved a criminal abortion statute which barred performance of a surgical operation. The section challenged by plaintiffs here merely provides that practitioners must furnish evidence of their services in order to be compensated.

To read *Doe v. Bolton* as holding invalid any regulation of physicians other than by licensure is unfounded as noted by the Second Circuit Court of Appeals in *Roe v. Ingraham, supra:*

> Also, we have not read the portion of *Doe v. Bolton, supra,* 41 U.S. at 198, 93 S. Ct. 739, striking down Georgia's "two doctor concurrence" requirement as meaning that a state is wholly without power to regulate the practice of medicine or the activities of physicians except by professional censure, deprivation of licenses, or enforcement of the criminal law. 480 F. 2d at 108.

Accordingly, plaintiffs' contention that the statute creates presumptions inconsistent with plaintiffs' licensure in violation of the Fifth Amendment is without merit.

G. Delegation of Authority to Private Organizations

Plaintiffs contend:

> Said law, and in particular Section 1152 of said law (42 U.S.C. Section 1320c–1), empowers private organizations that are inherently biased against plaintiffs by their contractual relationship with defendant and their economic self-interest, to exercise quasi-judicial authority over plaintiffs.
> . . . [Complaint, Part IV, Paragraph 11.]

In support of this argument plaintiffs rely on the case of *Tumey v. Ohio,* 273 U.S. 510 (1927), where the Supreme Court struck down a state statute which provided that certain crimes be tried before the Mayor of a town who received remuneration only if the defendant was found guilty. Plaintiffs argue that like the Mayor in *Tumey,* the PSRO's in the instant case will have a financial interest in retaining their contract. This argument is ill-founded for several reasons.

First, by statute, PSRO's must be non-profit organizations. 42 U.S.C., Section 1320c–1(c)(1). Second, these PSRO's will be reimbursed by the Secretary for their expenses, including the salaries of personnel performing review functions. 42 U.S.C. Section 1320c–4(f)(2). Accordingly, the

amount of salary is not related to performance as was the case in *Tumey v. Ohio, supra.* Membership in a PSRO is open to every physician in the PSRO's area, 42 U.S.C. Section 1320c–1(b)(1)(A); and all review of medical decisions must be made by physicians, 42 U.S.C. Section 1320c–4(c). Thus, plaintiff's allegation that these private organizations will be biased is totally without merit.

Finally, it has been held permissible for agencies of the Federal Government to contract with private organizations in order to have such organizations perform governmental functions as long as the particular administrative scheme provides for a hearing on the determinations made by those private organizations. See *State of Texas v. National Bank of Commerce of San Antonio,* 290 F.2d 229 (5th Cir.) *Cert. denied,* 368 U.S. 832 (1961), and *Coral Gables Convalescent Home, Inc. v. Richardson,* 340 F. Supp. 646 (S.D. Fla. 1972).

III

Valid Exercise of Congressional Power

Plaintiffs' final argument, buttressed by a lengthy amicus curiae brief filed by the Association of Councils of Medical Staffs of Private Hospitals, Inc., is a broad attack upon the legislation as an inefficient and unnecessary interference with their right to practice medicine. This Court has already held, *supra,* that the "Professional Standards Review" legislation does not unconstitutionally interfere with plaintiffs' right to practice their profession in violation of the Fifth Amendment.

Congress has enacted this legislation as a vehicle to better control expenditures of the Federal Government in connection with the Medicare and Medicaid Programs. In view of the already extensive presence of the Federal Government in the health care sphere, it can hardly be said that a statutory scheme designed to achieve better cost control in the field of health care is outside the competency of the Federal Government.

The means that Congress has chosen to attain these economic goals are not arbitrary and totally lacking in rationality. Underlying the constitutionality of the legislation is the fact that the program is a voluntary one in which a physician may freely choose whether or not to participate. However, should a physician choose to participate, he must then comply with these new requirements in order to be compensated for his services.

This legislation represents the first medical utilization review program that is national in scope. In attempting to avoid overutilization and to achieve better cost control in the health care field, the "Professional Standards Review" Law comes in close proximity to the rights of those physicians and other providers of health care services in the Medicare and Medicaid Programs. Yet there must be a balancing between those interests and the Government interest in providing and maintaining medical care to those most in need of it.

The "Professional Standards Review" legislation properly preserves that balancing of interests. In upholding the constitutionality of the legislation

on its face, ths Court does not reach the validity of the statute as it will be applied. Nor does this Court pass upon the wisdom of this particular piece of legislation. Whether the implementation and application of this statute may result in an unwieldly bureaucracy of monstrous proportions is a policy question for the consideration of the legislative rather than the judicial branch of the Government.

As the United States Supreme Court noted in upholding the constitutionality of a provision of the Social Security Act in *Richardson v. Belcher*, 404 U.S. 78 (1971):

> We have no occasion, within our limited function under the Constitution, to consider whether the legitimate purposes of Congress might have been served . . . or to judge for ourselves whether the apprehensions of Congress were justified by the facts. If the goals sought are legitimate, and the classification adopted is rationally related to the achievement of those goals, then the action of Congress is not so arbitrary as to violate the Due Process Clause of the Fifth Amendment. *Id.* at 84.

IV

CONCLUSION

For the foregoing reasons, defendant's motion to dismiss for failure to state a claim upon which relief can be granted, or, in the alternative, for summary judgment, is hereby granted.

The Cause is dismissed.

PART II, CUMULATIVE LISTING OF SELECTED COURT DECISIONS PUBLISHED AS RULINGS

Association of American Physicians and Surgeons v. Weinberger (professional standards review organization, PSRO designations, authority of Secretary, HEW, to implement the federal "professional-standards review" law) 79–62c (p.)

Carey v. Finch (hospital insurance benefits, emergency services) 79–55c (p.)

Fairfax Hospital Association, Inc., v. Califano (hospital insurance benefits, reasonable cost, related party supplier) 79–60c (p.)

Mercy Hospital and Medical Center San Diego v. Califano (hospital insurance benefits, provider reimbursement, cost of educational activities and allocation of net cost of educational activities to all departments of provider) 79–61c (p.)

Pigford v. Mathews (hospital insurance benefits, emergency services) 79–58c (p.)

Preuc v. Secretary of Health, Education, and Welfare (hospital insurance benefits, custodial care exclusion) 79–49c (p.)

PART III, Numeric Index of Final Decisions Rendered by the Administrator of Health Care Financing Administration on PRRB Decisions

78–D72—Cost of educational activities; Joint educational costs; Determination of cost of services; Special care units. (12/21/78)

78–D78—Interest expense; Offset of interest income for investments. (2/4/79)

78–D79—Interest expense; Cost related to patient care. (2/4/79)

78–D82—Related organizations (2/9/79)

78–D85—Lower of costs or customary charges. (2/15/79)

79–D1—Lower of costs or customary charges; Step down cost finding. (3/9/79)

79–D2—Purchase of land—not amortizable; Depreciable bases of assets; Interest expense. (3/19/79)

79–D3—Definitive observations units (3/12/79)

79–D7—Joint educational activities. (3/27/79)

Numeric Index of the Administrator Health Care Financing Administration Decisions to Remand PRRB Decisions

77–D47—Remanded by Order of the Administrator for further administrative action pursuant to Court's Order. (3/15/79)

78–D84—Remanded by Order of the Administrator for decisive decision by PRRB as to Issue 1—Interest expense—in lieu of PRRB's prior evenly split opinion; Remanded as to Issue 2 to preserve the Provider's appeal rights and to prevent fragmenting of the case. (2/12/79)

78–D86—Remanded by Order of the Administrator for decisive decision by PRRB as to Issue 2—Allocating the gain or loss on sale of the Provider—in lieu of PRRB's prior opinion which ordered the parties to obtain a binding appraisal; Remanded as to Issues 1 and 3 to preserve the Provider's appeal rights and to prevent fragmenting of the case. (2/15/79)

PART IV, Quarterly Listings of Published Health Care Financing Administration Program Regulations (Dec. 1978–March 1979)

The following amendments and additions to HCFA regulations have been published in the *Federal Register:*

1. 42 CFR Part 405—Reimbursement for Organ Procurement and Histocompatibility Testing and for Home Dialysis (43 FR 58370, December 14, 1978)

2. 42 CFR Part 405—Collection and Compromise of Medicare Overpayment Claims from Providers, Physicians, and Other Suppliers of Services (43 FR 59380, December 20, 1978)

3. Notice—Hospital Insurance Monthly Premium—Premium Rate for the Uninsured Aged (43 FR 61010, December 29, 1978)

4. Notice—Supplementary Medical Insurance for the Aged and Disabled (Part B of Medicare)—Monthly Actuarial Rates and Monthly Premium Rate (43 FR 61010, December 29, 1978)

5. 42 CFR Part 405—Payment Under Medicare for Items and Services Furnished by Indian Health Service Hospitals and Skilled Nursing Facilities (44 FR 2592, January 12, 1979)

6. 42 CFR Part 405—Clinical Laboratory Proficiency Examination (44 FR 2593, January 12, 1979)

7. 42 CFR Part 460—Redesignation of PSRO Areas in Illinois (44 FR 2594, January 12, 1979)

8. 42 CFR Part 405—Quality Control and Proficiency Testing Standards for Laboratories in Medicare Hospitals (44 FR 3288, January 16, 1979)

9. 42 CFR Part 405—Depreciation: Allowance for Depreciation Based on Asset Costs (44 FR 3980, January 19, 1979)

10. 42 CFR Part 405—Elimination of the Combination Method of Apportionment and Modified Cost Finding for Providers (44 FR 3984, January 19, 1979)

11. 42 CFR Part 441—Federally Funded Sterilizations (44 FR 5665, January 29, 1979)

12. Notice—Medicare and Medicaid Hospice Projects—Extension of Closing Dates for Hospice Project Applications (44 FR 5944, January 30, 1979)
13. 42 CFR Part 405—Effect of Capital Stock Transactions (44 FR 6912, February 5, 1979)

14. 42 CFR Parts 431 and 442—Skilled Nursing and Intermediate Care Facilities: Appeals Proceedings for Denial, Termination or Nonrenewal of Certifications and Provider Agreements (44 FR 9749, February 15, 1979)

15. 42 CFR Part 405—Reduction in Grace Period Days Where Payment Is Made for Certain Nonreimbursable Expenses (44 FR 17676, March 23, 1979)

16. 42 CFR Subchapter C—Medicaid Program—Redesignation and Rewrite (44 FR 17926, March 23, 1979)

17. Notice—Health Financing Research and Demonstration Grants (44 FR 18626, March 28, 1979)

PART V, HEALTH CARE FINANCING ADMINISTRATION INDEX OF ADMINISTRATIVE STAFF MANUALS AND INSTRUCTIONS

The Freedom of Information Act, as amended (Public Law 93–502) requires each government agency to make available for public inspection and copying all administrative manuals and instructions to staff which affect any member of the public. In order to give the public an understanding of what material is thereby available, agencies must provide a regularly updated index of pertinent titles. This index itself, like the manuals and other materials it lists, is required by law to be available to the public for inspection and copying upon request.

The Index which follows represents an update of instructions and other issuances issued through March 1979.

The Index will be maintained in all Health Care Financing Administration Regional Offices where it may be examined by members of the public. The office will supply photocopies of selected pages upon request. (There may be a fee charged for this service, depending on the quantity of material requested.)

Any questions regarding this index should be made in writing to:

HCFA
Bureau of Program Policy
6401 Security Blvd.
Baltimore, Maryland 21235

MEDICAID

ACTION TRANSMITTALS

The Action Transmittals are designed to transmit policies of the Medicaid program to individuals that participate and administer the program. A numeric listing of the Action Transmittals issued through March 1979 follows:

HCFA–AT–78–106 —Implementation of Sterilization Regulations Under Medicaid

HCFA–AT–78–107 —Public Health Service Pamphlets:
(1) Your Sterilization Operation: Information for Women
(2) Your Sterilization Operation: Information for Men

HCFA–AT–78–108 —Revisions to the Instructions for Preparation of the Quarterly Statement of Expenditures for the Medical Assistance Program Approved Under Title XIX

HCFA–AT–78–108 —Limitation on Payment or Reimbursement for Drugs

HCFA–AT–78–109 —Abortion Validation Reviews

HCFA–AT–78–110 —Utilization Control Validation Survey for the Quarter Ending 12/31/78

HCFA–AT–78–111 —Correction to Recodification of Medicaid Regulations

HCFA–AT–78–112 —Age Discrimination

HCFA–AT–78–113 —Clarification of Medicaid Eligibility Policy Regarding Work Expenses as a Result of Revisions in AFDC Treatment of Work Expenses

HCFA–AT–79–1 —Public Health Service Pamphlets in Spanish (Sterilizations)

HCFA–AT–79–2 —Preprinted State Plan Amendment on Federal Financial Participation in State Claims for Sterilizations

HCFA–AT–79–3 —Denial of FFP to Persons and Providers Excluded from Medicare Program Participation; and Program Suspension of Physicians and Practitioners Convicted of Medicare or Medicaid Related Crimes

HCFA–AT–79–4 —Convicted Physicians or Practitioners Suspended or Persons or Providers Excluded from the Medicare and Medicaid Programs

HCFA–AT–79–5 —Limitations in Payment or Reimbursement for Drugs NOI to Set MAC Limits

HCFA–AT–79–6 —Convicted Physicians or Practitioners Suspended or Persons or Providers Excluded from the Medicare and Medicaid Programs

HCFA–AT–79–7 —MMB Medical Assistance Manual—Personal Care Services in Recipient's Home

HCFA–AT–79–8 —Revisions to the Instructions for Preparation of the Quarterly Statement of Expenditures for the Medical Assistance Program Approved Under Title XIX

HCFA–AT–79–9 —Form HCFA–65, Quarterly Estimate of Expenditures

HCFA–AT–79–10 —Uniform Reporting Systems for Health Services Facilities and Organizations

HCFA–AT–79–11 —Proposed List of Medicaid Laboratory Tests Subject to Lowest Charge Level

HCFA–AT–79–12 —Preprinted State Amendment on Nondiscrimination on the Basis of Handicap

HCFA–AT–79–13 —FFP in Payments to States for Design, Development, Installation and Operation of Mechanized Claims Processing and Information Systems

HCFA–AT–79–14 —Convicted Physicians or Practitioners Suspended or Persons or Providers Excluded from the Medicare and Medicaid Programs

HCFA–AT–79–15 —Extension of Reporting Requirements for Quarterly Statement of Financial Plan (OA–25A and OA–25.5) Report is to be received by the Medicaid Bureau in DC not later than 2/15/79.

HCFA–AT–79–16 —Medicaid Sample Selection Lists

HCFA–AT–79–17 —Limitation on Payment or Reimbursement for Drugs

HCFA–AT–79–18 —Skilled Nursing and Intermediate Care Facilities: Appeals Proceedings for Denial, Termination or Nonrenewal of Certifications and Provider Agreements

HCFA–AT–79–19 —Schedule for Completion of Medicaid Quality Control Reviews

HCFA–AT–79–20 —Services: Requirements and Limits Applicable to Specific Services—Abortions

HCFA–AT–79–21 —Convicted Physicians or Practitioners Suspended or Persons/Providers Excluded from the Medicaid and Medicare Programs

HCFA–AT–79–22 —Medicaid Quality Control Difference Resolution

HCFA–AT–79–23 —Standards for a Merit System of Personnel Administration

HCFA–AT–79–24 —Reconsiderations and Appeals of PSRO Determinations

HCFA–AT–79–25 —Revisions to Edits in MQC Reports Manual Section 4000, Appendices A and B

HCFA–AT–79–26 —Abortion Claims

HCFA–AT–79–27 —Medicaid Quality Control State Affirmation Letters

Information Memoranda

The Information Memoranda are policy instructions and other informational material as deemed necessary to Medicaid program participants regarding certain aspects of the program that should be emphasized and elaborated upon because of problems which have been pointed out. A numeric listing of the Information Memoranda issued through March 1979 follows:

HCFA–IM–78–55 —State Medicaid Fraud Control Units Budget Application and Reporting Forms

HCFA–IM–78–56 —Study of Drug Formularies

HCFA–IM–78–57 —Listings of Certified Laboratories Participating in Medicare

HCFA–IM–78–58 —Implementation of ICD–9–CM in State Medicaid Systems

HCFA–IM–78–59 —National Conference on MMIS—Benefits to Management Albuquerque, NM on January 23–25, 1979

HCFA–IM–79–1 —Update of Chapter 3600, Claims Processing, The Review Process, Section 3000, The Medicaid Quality Control Manual

HCFA–IM–79–2 —List of Single State Agency Directors and Medical Assistance Unit Directors

HCFA–IM–79–3 —Payment for Durable Medical Equipment

HCFA–IM–79–4 —Technical Assistance and Consultation Resource List

HCFA–IM–79–5 —Eleventh Annual Conference of State Medicaid Directors, April 2–5, San Francisco

HCFA–IM–79–6 —Limitation on Payment or Reimbursement for Drugs; Notice of Intent to Set MAC Limits

HCFA–IM–79–7 —Seminars on Cost-Related Reimbursement for Long-Term Care

HCFA–IM–79–8 —Second Annual Eligibility Workshops

REGIONAL OFFICE MANUAL ISSUANCES

Manual

The Regional Office Manual (ROM) is the primary vehicle for policy and other program issuances to the Regional Offices. The manual is in looseleaf form to allow for easy addition, deletion and correction. It contains policy information explaining and clarifying material in the regulations. The organization of the major portion of the manual to conform to the arrangement of the Code of Federal Regulations will make it easier to use and to incorporate currently existing issuances (in particular PIQs) into the new system. A numeric listing of these ROM-Issuances issued through March 1979 follows:

ROM 1 —FFP in Expenditure for Determining Eligibility and Providing Services—FFP for Services: Clarification of Spend-Down Policy with Regard to a State's Practice of Billing Medicaid for the Total Cost Rather Than Net of the Spend-Down Amount (1/22/79)

ROM 2 —Relative Responsibility and Deeming of Income in 209(b) States (2/15/79)

REGIONAL LETTER SERIES

The Medicaid Regional Letter (RL) Series conveys material which has limited or no retention value. The RL Series includes informational and instructional material such as copies of reports and one-time requests to investigate certain areas. A numeric listing of these RLs issued through March 1979 follows:

RL 78–1 —Information—Reimbursement for Pharmacy Services—Usual and Customary Charge Comparison Required for Each Drug (12/21/78)

RL 78–2 —Tentative Schedule of Activities for the Utilization Control Validation Survey for the Quarter Ending 12/31/78 (12/22/78)

RL 79–1 —Regional Medicaid Directors' Conference Call (1/2/79)

RL 79–2 —Utilization Control: Instructions for Reviewing States' Quarterly Showings Under Section 1903(g) for the Quarter Ending 12/31/78 (1/8/79)

RL 79–3 —Directive—1st Quarter FY 79 Medicaid and HCFA Work Plan Reports Due January 30, 1979 (1/2/79)

RL 79–4 —Information—Medicaid Briefing Slides (1/12/79)

RL 79–5 —Utilization Control Validation Survey for the Quarter Ending 12/31/78 (1/12/79)

RL 79–6 —NOT ISSUED (ISSUED AS ROM)

RL 79–7 —Definitions of Items Comprising the Record Supporting Disallowance Actions (1/23/79)

RL 79–8 —Distribution List for State Management Review Reports (1/23/79)

RL 79–9 —ACTION—State Assessments (1/23/79)

RL 79–10 —Monthly Regional Report on Savings and Cost Avoidance (1/26/79)

RL 79–11 —Recission of Requirement for a Description of Methods of Administration for Section 504 of the Rehabilitation Act of 1973 (Non-Discrimination Based on Handicap) (1/30/79)

RL 79–12 —Status Report on Recommendations Made by Ad Hoc UC Committee in New Orleans, October 31, 1978 (2/15/79)

RL 79–13 —Information—Allocation of Eligibility Determination Cost for Title XIX FFP (2/15/79)

RL 79–14 —Medicaid Quality Control Data Network (MQC—DATA-MED) (2/23/79)

RL 79–15 —ACTION—State Assessments (2/23/79)

RL 79–16 —ACTION—State Assessment Review Findings (2/26/79)

RL 79–17 —Implementation of ICD–9–CM (2/28/79)

RL 79–18 —ACTION—Priorities for Review by Financial Management Staff During FY 1979 (3/5/79)

RL 79–19 —ACTION—Reporting on Improved Party Liability Collection Activities (3/5/79)

RL 79–20 —MQC Field Visits to States to Assess Progress (3/14/79)

RL 79–21 —ACTION—Report on States' Cost Savings and Avoidance Measures (3/15/79)

RL 79–22 —Information—Responsibility for Monitoring States' Compliance with Abortion Regulations (3/20/79)

RL 79–23 —Information—FY 79 State Reimbursement Plans for Long Term Care Facilities (3/21/79)

RL 79–24 —Training Session on Medicaid Management Information System (MMIS) Tracking and Reporting (3/21/79)

HEALTH STANDARDS AND QUALITY BUREAU

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TRANSMITTALS

The Professional Standards Review Organizations (PSRO) transmittals contain administrative, procedural, and policy instructions for use in administering the PSRO program. A numeric listing of these PSRO transmittals issued through March 1979 follows:

PSRO Transmittal No. 84 —Transferring of PSRO Review Responsibilities to Third Parties by Means of Subcontract or Contract (12/11/78)

PSRO Transmittal No. 85 —Revision of PSRO Data Processing Funding Limitation (12/26/78)

PSRO Transmittal No. 86 —PSRO/State Survey Agency Information Sharing (12/26/79)

PSRO Transmittal No. 87 —Revised Federal Reports Manual (FRM) (1/2/79)

PSRO Transmittal No. 88 —The Integration of End-Stage Renal Disease (ESRD) Medical Review Board (MRB) Functions and PSRO Review Responsibilities (1/15/79)

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Health Care Financing Administration
Baltimore, Maryland 21235

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